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## ORIGINAL DEPARTMENT.

### COMMUNICATIONS.

#### PREGNANCY NEPHRITIS.

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[Read before the State Medical Society of Delaware, June 12, 1883.]

Dr. Bright, in 1827, first showed the co-existence of albuminuria with certain morbid conditions of the kidneys. Later researches in reference to renal diseases have proven that the presence of albumen in the urine, while always to be regarded with suspicion, is not so invariably associated with renal disease as was formerly supposed. As occurring in the urine of persons with apparently healthy kidneys, it may be due to an excess of albumen in the blood. This may be the result of dietetic errors, or alimentary derangements. "Barreswill passed albuminous urine for twenty-four hours after eating ten eggs; and Beneke four times in as many weeks detected albumen in his urine while suffering from dyspepsia."

Exceptionally we find albuminuria in certain rare forms of hepatic disease, and it has been known to exist as a sequence to the rapid absorption of a pleuritic effusion.

Any interference with the renal circulation, whether caused by irritation of the renal nerves, or by pressure on the renal veins, produces albuminuria. The prolonged use of certain medicinal agents, which are eliminated chiefly by the kidneys, causes albuminuria, probably by irritation and over-stimulation of the renal epithelium and interference with its proper nutrition.

Bartholow has for a long time held the opinion that this is a frequent cause of chronic Bright's disease.

Lastly, the presence of albumen as a constituent of other fluids, as blood, pus, and semen occasionally mixed with the urine, must not be overlooked.

While most of the conditions just considered have little pathological significance, a knowledge of them is essential to a correct appreciation of albuminuria resulting from causes having a more serious import. Albuminuria of pregnancy is particularly deserving of attention on account of its frequent association with important puerperal diseases, notably, eclampsia.

When Lever, in 1843, found albumen in the urine of some patients suffering from puerperal eclampsia, the key-note of the latter disease was supposed to have been struck. He asserted that albuminuria always preceded the convulsions, and later, Sir James Y. Simpson insisted that the convulsions were essentially uræmic in their nature. Braxton Hicks, however, has shown that in some instances albuminuria follows, and does not precede eclampsia. While it is not probable that puerperal convulsions ever occur without renal disturbance, albuminuria is often present during pregnancy without renal disease, and independent of the puerperal state. Abeille found albuminuria in one out of every ten pregnant women, and according to the researches of Blot and Litzman, the condition was present in twenty per cent. of pregnancy. "Dr. Roberts, from a consolidation of the statistics of several observers, infers the liability of pregnant women with albuminous urine to eclampsia to be about one in

four." Of these, about one-third prove fatal. The fact that not all the fatal cases of Bright's disease of pregnancy end in convulsions should not be overlooked. Convulsions are most liable to occur in the earlier stages of renal disease, and in those cases not characterized by the usual obvious symptoms. In the cases which have attained considerable degree of granular degeneration there is probably more liability to death by simple coma, although this may occasionally be preceded by convulsions. Since uræmia predisposes to serous inflammations, death may occur from one of these.

On account, probably, of the impoverished condition of the blood, and the consequent ill nourishment of the fetus during pregnancy nephritis, there is a strong tendency to abortion, and the subjects of Bright's disease who are prematurely confined most probably escape the eclamptic complication. The earlier the abortion, the less likely in these cases is eclampsia to supervene. Dr. Tanner states that four out of seven women he attended, suffering from Bright's disease during pregnancy, aborted, one of them three times. Dr. Reginald Southey, in a lecture which we find in the *Lancet*, January 13, 1883, describes three forms of pregnancy nephritis:

1. Eclampsia parturientium, a series of epileptiform convulsions, concurring with the act of parturition, and coinciding with highly albuminous and scanty urine, and preceded by no well defined or obvious symptoms of renal disease. Usually, however, the subjects of this form have some rather subjective symptoms, such as dizziness, and a lachrymose condition, indicating renal changes. These retinal symptoms are often the only ones present. The subjects are apathetic, and often have a peculiar huskiness of voice. Sometimes slight paralysis occurs. These symptoms concomitant with pregnancy should always lead to an examination of the urine.

2. Chronic, insidious, parenchymatous nephritis, complicated by pregnancy, increasing *passu* with each succeeding week of pregnancy, and hastened and made more immediately dangerous by uræmic symptoms or local inflammatory complications. This form, chronic Bright's disease, renal fibrosis, or the so-called granular degeneration, is less common than the other forms and may have had its origin in a former pregnancy or from other causes.

3. Pregnancy nephritis proper, an acute change in the nutrition of the renal epithelium, beginning from the third to the sixth month of pregnancy. This form, which we find most common,

is attended by albuminuria, general œdema, albuminuric retinitis, uræmic symptoms, eclampsia, and sometimes death. Often, however, the disease is suddenly terminated by premature labor, subsequent profuse diuresis, and complete recovery. A considerable proportion become chronic and prove fatal in subsequent pregnancies. The following case is reported as one of pregnancy nephritis proper, and on account of the unusual disease with which it was followed:

Mrs. M. P., æt. 30 years, came under my notice June 8, 1882, while in the seventh month of her sixth pregnancy. She presented a pallid countenance and general anasarca. There was anorexia and a slight inclination to diarrhœa. Ocular and cerebral disturbance indicated albuminuric retinitis. Pulse, 78; temperature normal; respiration 28. The urine was scanty, high colored, and contained a small quantity of albumen and a few granular casts. Specific gravity 1025. The following morning the patient was delivered of a still-born child. Labor proceeded and ended without any untoward symptom. The placenta was delivered naturally, no ergot having been used then or afterwards. After delivery marked diarrhœa set in and the swelling began rapidly to subside. The urine became more copious, and in six weeks contained neither albumen nor casts. About a week after her accouchment a painful swelling appeared about the centre of the left cheek. On the inside of the cheek, near the orifice of Steno's duct, was a hard, painless, dirty-grey spot, from all the surface of which soon issued a thin, sanious discharge, giving to the breath a most offensive odor. The sublingual and submaxillary glands on the affected side were enlarged. In a few hours the gangrenous portions were converted into a dark, fibrinous pulp, and within three days had extended through the cheek, forming a black circle, which rapidly spread in all its circumference until it became the size of a silver dollar. The destructive process involved the entire thickness of the cheek, and extended to the contiguous portions of gum, laying bare a part of the alveolar process. A few thorough applications of fuming nitric acid were made, and the mortification was soon arrested. The internal medication consisted of pot. chlorat., acid. hydrochloric. and tinct. ferri chloridi. The patient slowly recovered on a generous diet of milk, eggs, and animal broths. The temperature ranged from 102° to 104° during the gangrenous condition, and the pulse was weak and correspondingly accelerated. The family history of the patient was good, and at no time

during her sickness was any preparation of mercury used. There were no other sore spots in the mouth. In three weeks the wound healed kindly, contractions of the cheek leaving a round hole the size of a twenty-five cent silver piece. This was subsequently closed by a plastic operation. *Cancerum oris*, or *noma*, is a disease peculiar to childhood, and I have never seen the record of a case happening in a patient so old as this. Gangrene of the mucous membrane occasionally follows the aphthous stomatitis which frequently occurs as a complication of typhoid or puerperal fever. The case just described apparently did not have its origin in this aphthous condition, and while the squalor and ill nourishment of the patient were remarkable, the disease is probably of that character which happens with septicemia and typhoid fever.

Just what degree of degeneration of the kidneys is consistent with recovery is not known. Cases undoubtedly occur in which recovery is apparently complete even after considerable fibrosis. In these cases resolution does not probably occur, the pathological process being merely arrested. There is sufficient renal structure unimpaired to perform the adequate functions of secretion. The morbid action in all these forms is essentially the same, differing only in intensity or degree of progression.

Dr. Braun, from observations based on the results of twelve autopsies of women who had died of puerperal convulsions, describes the kidneys as being in one of three conditions:

First. That of intense congestion. The cortical substance is dark, soft and friable. The parenchyma is infiltrated with tenacious, sanguinolent fluid, and hemorrhagic effusions are not uncommon.

Second. There is fatty degeneration of the Malpighian bodies, which gives to the kidneys a dull yellow color. The surface is sometimes smooth, but more often presents a granulated or partly granular appearance. In this form the kidney is larger than natural.

In the third stage the kidneys are reduced to their natural size, or below it. "The Malpighian capsule is thickened. The surface of the kidney is uneven, tuberculated, and often shows deep furrow-like indentations, dividing it into lobes. The cortical substance is wasted, and the organ is generally tough in texture."

Granular degeneration of the kidney resulting from heart disease has always a red appearance on section, while that arising from pregnancy almost invariably presents a dull yellowish color

from fatty degeneration. While renal disease may exist during pregnancy, and independent of it, there is abundant clinical evidence proving that the puerperal state is a fruitful exciting cause of Bright's disease.

Dr. Wm. Roberts, in reference to the report of the Registrar-General of England in 1874, quotes the following: "In the five years between 1857 and 1861, 6,220 deaths were registered from Bright's disease. Of these, 3,699 were males and 2521 females—the relative proportions of the sexes at all ages being sixty-eight females to every hundred males: but during the child-bearing period (from twenty to forty-five) the proportions were eighty women to every hundred men, while after the age of forty-five the proportional mortality from Bright's disease fell to fifty-nine women for every hundred men.

The intimate nature of the pathogenic cause of Bright's disease, and what relation pregnancy bears to it is unknown. Many able writers attribute the changes in the kidneys to pressure of the enlarged uterus on the renal veins, while others account for the disease in the impaired condition of the blood. In favor of pressure we have the following well-established facts:

(1) That pregnancy nephritis proper does not usually begin until after the fifth month, and therefore not until the uterus has attained considerable size.

(2) That the disease originates mainly in primiparæ, in whom the resistance of the abdominal walls, and consequent pressure, are greater than in those who have already borne children.

(3) That it complicates twin rather than single pregnancy.

(4) That after parturition the anasarca and albuminuria rapidly subside.

"Bartels has shown that the renal veins occupy such a position as secures them against pressure," and as so many pregnant women escape the complication of albuminuria, and even greater pressure is often exerted in the same place by ovarian and other tumors without such consequences, it is evident that in many cases there is probably some special predisposition on the part of the patient to the disease in question. As auxiliary to mechanical pressure, we might look to the condition of the heart. It is well known that hypertrophy of the left ventricle is a natural condition of pregnancy. The addition of the placental to the systemic circulation involves a considerable addition to the work of the heart. In Bright's disease, also, the cardiac hypertrophy is often remarkable; "occurring, probably, in consequence

of increased arterial blood pressure, the result of some obstruction to the movement of the blood in the minute vessels." This obstruction is probably due, as Bright supposed, to an alteration in the quality of the blood, which causes it to pass with difficulty through the capillaries. Drs. Gull and Sutton consider that the renal changes are concomitant with "arterio-capillary fibrosis," but it is more than likely that this "hyalin-fibroid" condition is consequent upon rather than standing in a causal relation to the renal disease. Regarding the initial changes in Bright's disease there is a diversity of opinion. The most plausible theory, however, is, probably, that the morbid process begins in the epithelium of the glomeruli and of the uriniferous tubes.

Prof. Stricker, of Vienna, and his assistant, Dr. Spina, in some researches made on the cells of glands, have discovered that the cells lining the glandular vesicles, which are sometimes so small as merely to form a lining membrane for the relatively large lumen, may, under certain stimulation become so large as to entirely fill up the lumen. The cells retract if the stimulation be not too strong, but if too powerful or long continued, the cells swell up sufficiently to occlude the lumen and cease to functionate.

Now, if, as is asserted by Isaachs, Gerlach, Moleschott and Chrzonszczensky, the epithelial lining of the Malpighian capsule covers the whole of the Malpighian tuft, the capsule is virtually a glandular vesicle, having an excretory duct which doubtless has, besides acting as a duct, a special function of its own relative to secretion, (*vide* "Pathology of Inflammation," S. Stricker, "Encyclopædia of Surgery," Ashhurst, vol. i, pp. 10 and 11). The functions of these are probably carried on after the manner suggested by Stricker and Spina, viz., by alternate swelling and retraction of the epithelium lining the acinus of the gland; the increase of volume necessitating absorption of fluid from the surrounding tissues. These cells, of course, secrete urine by their power of selective action. Might not the irritation of pressure or functional overstimulation, or both, occasion permanent enlargement of these cells, and consequent functional annihilation? After death, these cells undergo granular degeneration, and many crumble and disintegrate. Dr. Geo. Johnson has long held the opinion that the morbid process of desquamative nephritis always began in the renal epithelium, and that the epithelial cells crumbled and disintegrated.

The writer suggests that this granular degeneration is a fatty metamorphosis, and the cells

which have undergone degeneration are identical in nature with the corpuscles which Gluge found in the commencement of pneumonic infiltration of the lungs, and which were afterwards proven to be fatty degenerated epithelium of the lungs. "These were displaced from their seat by the oedema preceding the inflammation and then degenerated." The granular matter often found filling the tubes and studding the casts, results from the degeneration of cellular elements, and, as suggested by Green in reference to Gluge corpuscles, many of the granules are probably myelin, and not fat. It is doubtless a disturbance of nutrition which brings about the changes in the epithelium, and this latter change causes the alterations of the parenchyma. Dr. Aufrecht, in Magdeburg, in a series of experiments made for the purpose of determining the starting point of the inflammatory process of Bright's disease, was able to demonstrate on kidneys, the ureters of which had for a long time been tied, that in the beginning the epithelium alone was affected by becoming granularly opaque and by throwing off fibrinous casts. "During the first few days the interstitial tissue continued intact. On the fourth day the capsules of Malpighi were commencing to enlarge, which the interstitial spaces began to do at the same time, nuclear swelling of the local cellular tissue being in either case the cause of enlargement. The walls of the vessels became thicker and mainly in consequence of the swelling of the cells of the adventitia and of the muscular fibre. The epithelium of the uriniferous tubes shows synchronously another alteration: it changes to small, pale cells with plainly visible nucleus, but it is not destroyed. While the lumina of the tubules becomes narrower, the interstitial spaces enlarge continuously in consequence of nuclear swelling and augmentation of cells." Dr. A., by the injection of small quantities of cantharidin suspended in oil, succeeded in bringing about all the forms of nephritis progressively, viz., acute parenchymatous, diffuse parenchymatous, interstitial, and the cirrhotic or granular kidney. "All these forms had the same pathogenic cause, the most progressed stage—cirrhotic kidney—being in direct relation to the most frequent applications of the drug employed. First the capsular epithelium began to swell and the glomerulus was thereby pushed away from the wall. The epithelium of the tubes becomes turbid, swells and contains brilliant formations all over the cell. Of these brilliant formations the tube-casts are formed—the same condition as noted after ligation of the ureter



of one kidney" (vide *MEDICAL AND SURGICAL REPORTER*, vol. xlviii., May 5, 1883). Fibroid degeneration results from long-continued hyperæmia, which causes disturbances of nutrition.

*Treatment of Nephritis of Pregnancy.*—Eclampsia parturientium with albuminous urine may be relieved by such remedies as allay spasm. Chloroform, when there are no symptoms of cerebral hemorrhage. Full doses of chloral and bromide of potassium may arrest the convulsive seizures. Inhalations of amyl nit. are often beneficial. The hypodermic injection of morphia, originally practiced by Scanzoni, is the most important agent for the cure of uræmic convulsions, puerperal or non-puerperal. Venesection, properly performed on proper subjects, is doubtless of great utility. Cases requiring blood-letting are those characterized by intense cerebral congestion. Opinions differ as regards the propriety of hastening labor. Some recommend immediate emptying of the uterus even when labor has begun. Others prefer to leave the labor entirely to nature. If convulsions always ceased with the completion of labor this would indicate the necessity of hastening delivery. "Von Weiger, who tabulated 455 cases showed that the convulsions preceded the commencement of labor in 109 instances, attended the act of parturition in 236, and followed its completion in 110. Chronic Bright's disease demands the ordinary treatment for this affection. The patient should be confined in bed, and between blankets. The skin and bowels should be made to act vicariously by promotion of their functions. The labia if much swollen should be punctured with a fine needle, or perhaps better, by fine canulas. In pregnancy nephritis proper, the induction of premature labor is unquestionably indicated. The earlier the operation is performed the better. Prof Schroeder, of Berlin, urgently advises the termination of labor at once when albuminuria makes its appearance during pregnancy (*Amer. Jour. of Obstet.*, 1881). The risks of the operation are small as compared with the dangers of convulsions or of chronic Bright's disease.

#### A NEW TREATMENT FOR INTESTINAL OBSTRUCTION.

Synopsis of a paper read by C. W. Spicer, M. D., before the District Medical Society of Northwest Mo., at its quarterly meeting held at St. Joseph, April 12, 1883.

MR. PRESIDENT AND GENTLEMEN: A year or more ago the subject of intestinal obstruction being under discussion by the members of this society,

I reported a case of intestinal obstruction, probably from intussusception, which had recovered by the use of large enemas of warm water retained by force applied externally to anus. That case had progressed from bad to worse in the hands of other practitioners for three or four days before I was called, and had had the usual treatment of enemas, mild and drastic purgatives, opium, etc. I, in the case of that four-year-old child, injected per anum about three pints of water at 100° F. and removing the syringe tube, applied pressure to anal orifice sufficient to compel retention of the enema. At the end of forty-five minutes all peristaltic and other efforts to expel the injected matter ceased, and in about another half hour the child had a large natural fecal evacuation and was well, and so continues.

The case I wish now to report is that of H. G., male, aged 9 months, a well nourished infant weighing twenty-five pounds; living only upon its mother's milk; had had a slight diarrhœa for two or three days, for which it had been given a little syrup rhei aromatic.

At 11 a. m., March 22, 1883, while the child was amusing itself upon a rug, it turned suddenly very pale and commenced vomiting and gasping for breath; and seemed almost in a condition of collapse. I was called at 4 p. m., same day; was told by the father, who was the messenger, that the child had not urinated during the day, and that he supposed that its kidneys were the only organs at fault. Upon arriving at residence of patient, found him as before stated, almost in a condition of collapse. Made a thorough examination, and found no hernia or anything else to account for his condition, except a slight dullness of upper left chest with harsh respiration. Made a diagnosis of pulmonary congestion to end in probable capillary bronchitis, as that was at the time prevalent in the vicinity. Ordered a hot bath, also

R.	Ol. ricini,	℥j.
	Ol. terebinth.,	gtt. vii.
	Syr. gum. acacia,	q. s. ad ℥iij.

M. A teaspoonful every three hours until its bowels act well, and when reaction should take place:

R.	Tinc. aconite,	gtt. ½.
	Spts. nitr. dulc.,	gtt. x.
	Aqua.	A teaspoonful,

every two hours if the reaction was too great. At 5 p. m., patient considerably revived; had a large discharge from his bowels, consisting of bloody serum with a small amount of blood and mucus, no fecal matter; still vomiting; could

retain nothing; seemingly in great pain; my previous diagnosis considerably shattered; concluded that intestinal obstruction was the trouble, and probably from intussusception.

March 23, 8 a. m. Patient did not rest last night; in great pain; had had several passages from its bowels of bloody serum, with some mucus, no fecal matter; reaction fully established; pulse 140; vomiting whenever it swallows anything. Ordered small quantities of pounded ice for it to swallow. 6 p. m. Patient about the same as in the morning; ordered a mild alkaline aloetic mixture hourly until bowels commence rumbling, then a large injection of soapy water to be used.

March 24, 3 a. m. Has retained the aloetic mixture; has had several injections, which were returned unchanged, except by the addition of a little mucus; patient much worse; had not slept any during the night; pain severe and bowels tender upon pressure. Injected thirty ounces of water at a temperature of 99° F., compelled its retention by a pad over the anus, held in place with my hands against the efforts of the child to discharge the enema, by a force sometimes of as much as twenty pounds or more to the anal orifice. At the end of fifty minutes all peristaltic and abdominal action ceased, and child went into a quiet sleep, which continued for five hours; awoke, looking much better; had two fair-looking discharges from bowels, fecal matters with much mucus and a few shreds of blood-stained mucous membrane, but none of the water injected; during the day vomited fifteen to twenty ounces of clear water, which had a sour, putrid smell of fecal matter.

March 25, 2 a. m. Patient again restless; has slept but little since yesterday forenoon; has had no discharge from bowels since yesterday morning; has vomited everything taken; is not so greedy for the ice; pulse, 140; bowels tender, not much swollen. Now inverted the child; had him held in that position, of head down and heels up, and injected thirty-two ounces of water at 99° F.; compelled its retention as before, and kept the child inverted until expulsive movements ceased, in forty-five minutes; child asleep in fifteen minutes; had a good quiet sleep of six and a half hours; awoke looking much better; had no discharge from its bowels to-day; did not vomit as much as usual. 6 p. m. Ordered *ol. ricini*, ʒij. every two hours until bowels rumble, then injections of soap-suds, which was done with no effect; oil vomited and enemas discharged unchanged.

March 26, 2 a. m. Again sent for; child rest-

less; has slept none during the night; pulse, 120; pain paroxysmal; inverted the patient and injected thirty ounces of water at 101° F.; *tr. opii.*, gtt. v.; child asleep in five minutes; expulsive efforts continued for forty-five minutes, requiring more force than at any previous time to retain enema; child slept eight hours; had two bad-smelling fecal discharges; seems very hungry; beside the mother's breast, which is ordered to be kept well drained before letting the child to it, he takes with great relish a tablespoonful of good sour buttermilk hourly; does not vomit any more; appears a little sore over its bowels and quite weak, otherwise in good condition, and at the present writing, April 12, 1883, is in good health.

Please note the points: First, the great relief afforded by the forcible detention of the enemas until the complete cessation of all immediate expulsive efforts. Second, the great force or power required to prevent the immediate expulsion of the matters injected.

Intestinal obstruction, authorities tell us, may be from many causes, as strangulation by membranous bands the result of inflammation, twist of the bowel caused by its rotating upon its own axis, mesenteric or omental hernia, intussusception or invagination, and it might arise from a large collection of intestinal worms or foreign bodies within or pressing upon the tube, such as tumors, etc.

This particular case, from the suddenness of the attack, from its age and surroundings, I am of the opinion was caused by invagination or the slipping of one portion of the intestine into another. Statistics also show this to be the most frequent cause of intestinal obstruction.

The treatment followed is original with me so far as I know. Most authors speak of injections of water, air, etc., but the forcible retention of the matters injected I have not seen recommended. I think it is proper and really the only treatment, except by the knife, calculated to do good, and why it is so is this: by applying outside support to the anus you furnish a fulcrum, from which, when the lower portion of the bowel is filled with a material so divisible and yet so inelastic as water, you get a fixed base, and as the peristaltic action of the bowel, aided by contractions of the abdominal muscles, constricts portions of the tube, its contents (the water) not being allowed to be ejected, and pressing upon all sides alike less its weight, in accordance with natural laws, the point of least resistance is the first to yield. So by furnishing an unyielding plug, as it were, to the anal orifice, it must yield at

some other point; and in these two cases, I am glad to say, has been, by pushing back the invaginated bowel and the consequent relief from the obstruction of the bowel, assuming its normal relation.

I will say, in conclusion, that the two cases reported are the only ones in which I have tried this method of treating intestinal obstructions; but with these successes before me, I have no desire for that dangerous, often unnecessary, and uncertain operation, abdominal section, which of itself often causes fatal results, where, at least, the harmless method, which I have tried to explain, might produce a cure, and it certainly will not of itself kill.

## HOSPITAL REPORTS.

CLINICAL LECTURE ON DISEASES OF WOMEN,  
DELIVERED AT THE COLLEGE OF  
PHYSICIANS AND SURGEONS,  
NEW YORK.

BY PROF. T. GAILLARD THOMAS.

Reported for the MEDICAL AND SURGICAL REPORTER.

### Batley's Operation for the Relief of Excessive Dysmenorrhœa Caused by Fibroid of the Uterus.

GENTLEMEN: Some of you will have the opportunity to-morrow of seeing me perform Batley's operation at the Woman's Hospital; but as the number of those of you who can be present is necessarily very limited, I will say a few words before commencing our regular clinic in regard to the case, which is one of great interest. It is one of uterine fibroid, which is not now increasing in size, and which does not give rise to hemorrhage, and yet which occasions such frightful suffering that the extreme measure of performing Batley's operation is to be resorted to. For a considerable portion of every month the patient has no trouble, but about five days before the return of the menstrual period she begins to suffer the most dreadful agony, which continues through the flow (which lasts five or six days) and for two or three days afterward. In consequence of this she has to be kept in a semi-narcotized condition with morphia for fully twelve days, and often a longer period, of each month. As a result of this, the lady is becoming a confirmed opium-eater, and in addition, has gotten into such an extreme nervous state that nothing can be done for her until the cause of her sufferings is removed. This is what we propose to do, if possible, by putting an end to ovulation, the monthly recurrence of which is apparently accompanied by such intense distress. This, you must understand, is an exceptional and very peculiar case, and it is on this account that I have thought it worth while to take up a few moments of your time to refer to it. The fibroid of the uterus, I may say in passing, is about the size of a man's fist.

### Rupture of the Perineum, Followed by Prolapsus Uteri, Cystocele and Rectocele.

Our first patient to-day is Mrs. Elizabeth M—, 36 years of age, and a native of the United States. She has been married sixteen years, and has had seven children and four miscarriages. In reply to my inquiries, she says that she has been complaining for the last five years, and that it is her head that has given her the most trouble during that time. In addition, she has had more or less nausea and vomiting, and weakness and trembling about the anus. Her back troubles her a good deal, so that she cannot stand erect without considerable pain in it; and she is growing worse all the time instead of better. Her limbs are in good condition, she says, but she cannot retain her urine. At the same time she is able to pass it voluntarily when she wishes to. Her monthly sickness comes sometimes every three weeks, and sometimes every five weeks. She loses a large quantity of blood, but does not suffer especially at that time. Finally, she is troubled with leucorrhœa.

You will notice that almost all the symptoms of which this patient complains are of a very general character, rather than local. Amongst them the weakness in the head and back seem to give her the most trouble. Suppose, now, that she had consulted a specialist in diseases of the stomach. He would probably have supposed that the difficulty was primarily in this organ, on account of the gastric irritability present, and would have directed his treatment especially to this. He might, indeed, have afforded her a considerable amount of relief by pursuing such a course as this, but he certainly could not have cured her.

Then, again, she might have gone to a specialist in neurology, who would, no doubt, have noticed particularly the spinal weakness and the difficulty of locomotion, the incontinence of urine, the head symptoms, etc., and would perhaps have made an ophthalmoscopic examination. Then he would have arrived at some diagnosis or other which we need not take time to discuss here, and would have found abundant support for it in the symptoms of the patient. But instead of going to any such specialists, she has come here to a clinic for diseases of women, and we naturally instituted an examination of the pelvic organs, when the apparently obscure case at once became perfectly clear. I think it altogether probable, however, that if this patient had presented herself at a general clinic, a correct diagnosis would not have been made. This would certainly not have reflected on the gentlemen examining her case, because the symptoms do not point at all strongly towards trouble with the pelvic organs. The only ones that point in this direction are the pain and distress in the back and pelvic region, the excessive flow of blood at the menstrual period, and the leucorrhœa.

When a vaginal examination was made, it was found that a clean sweep had been made of the parts within the vulva and the rectum; there being a complete loss of the perineal body.

I will now show you by a rough diagram on the blackboard the condition of affairs discovered; and you will notice that, contrary to the representations of the vagina found in the plates of all the standard works, such as Gray's Anatomy, for

instance, I draw the anterior and posterior walls directly in apposition with each other. This is just as the vagina actually is in life, the anterior wall resting upon the posterior when the woman is in the erect posture; and the sooner that you can disabuse your minds of the idea (which one would derive from such plates as I have referred to) that the canal is kept distended by a sort of spiral spring, the better it will be for you.

In one of the labors of this patient the head of the child has torn away the perineum, and all the symptoms of which she to-day complains have resulted from this unfortunate accident. The gap thus made did not heal, but the torn surfaces became covered with mucous membrane, and there was nothing very bad about the appearance of the parts. Still there was mischief going on steadily all the time; for, whereas there had formerly been a buttress of support in the perineal body, so that as the patient walked about, the posterior wall of the vagina rested securely upon it, now this support was completely done away with. Before the injury, the perineum had been like the "C" spring sometimes run in old-fashioned coaches; but now the parts, instead of being of a C shape, are like that of the letter S. Consequently, the posterior wall of the vagina, deprived of its natural support, began to fall, and the anterior wall resting upon it and borne down by the weight of the bladder, commenced to descend also. The result was that the uterus, too, by the traction of the two vaginal walls, was dragged down with them. The rupture of the perineum has thus caused all the trouble. Five years ago the accident occurred, and matters have been growing steadily worse ever since. The uterus, sinking lower and lower, is now in the first stage of prolapsus; but as the patient grows older, it will gradually come to the second stage, and finally the third stage, or complete procidentia, as it is called, will be reached. The whole uterus will then be outside of the body, and when this occurs the woman will really feel better. All the time the organ is in process of descent intense suffering is experienced from the reflex symptoms resulting from the strain on the ligaments and other pathological factors; but when nature once gives up the long struggle, there follows a time of comparative repose. Although the woman may not suffer so much actual pain, however, the amount of inconvenience, from locomotion, etc., is usually greater than before the third stage of the prolapsus was reached.

At the present time the descending anterior and posterior vaginal walls are carrying the bladder and rectum down with them, and a point has now been reached when the most dependent portions of both of these are entirely outside the vagina. As to the general symptoms, the headache, the gastric derangement, the weakness in the knees, the pain in the back, and the general feeling of discomfort about the pelvis, all result from this prolapsus uteri. The remedy required here is to repair the damage done at the confinement, when the child's head tore through the perineum, and at the same time direct our attention to the removal of the indirect effects of the injury.

Such a patient as this should enter the hospital, as she could be treated with much greater

facility in such an institution than in her own home.

Once every day the uterus should be pushed up quite to its normal position, and then retained there by means of a tampon saturated with glycerine, which, by its well-known hydragogue action, would have an excellent effect in relieving the congested state of the parts with which it came in contact. In a short time the operation of perineorrhaphy would then be performed. Whether the patient would have to wear an abdominal bandage afterward, would depend on whether the abdominal walls are protuberant or not. If they are not protuberant, the bandage would be of no service whatever; but in case they are, the amount of benefit to be derived from such a bandage would correspond with the degree of protuberance. In addition to the local treatment, she should be given suitable tonics, and her general health carefully looked to; and in six months I should expect to find our patient very greatly improved in every way, and to have gained ten or fifteen pounds in weight.

I presume that scarcely any of you will have been in practice a year without meeting with one or two such cases as the one now before you, prolapsus uteri with inversion of the walls of the vagina. The symptoms, however, will vary very greatly in different instances. Thus, it is not at all uncommon to find in the condition here present that chronic cystitis has resulted. This is because, on account of the sinking down of the bladder, it is impossible for the patient to completely evacuate it, and the ammoniacal degeneration of the residual urine sets up cystitis. In other cases the backache is a more distressing symptom than in the present instance, and if the patient is a lady of wealth she will probably remain confined to bed the greater part of the time.

#### Multiple Uterine Fibroids.

Our next patient is Mrs. Sarah B—, born in the United States, and forty-five years of age. She has been married for twenty-five years, and has never been pregnant. She states that she has been really sick only for the last five or six months, but has been ailing for something like twenty years before that. What she has complained of is pain, and what she calls a "fluttering" in the right side, and these have grown worse during the last few months. She says that her monthly sickness disappeared five months ago, and that ever since then she has been suffering more. In regard to her menses, when she was young, she states that she never flowed too much. As to the sterility, she tells me that so far from doing anything to prevent conception, she was always anxious to have children. There is nothing else that she complains of except the pain and fluttering in the side; but of late she is not able to walk about much, on account of the distress which the exercise occasions her.

It is altogether probable that this patient's ailment commenced twenty years ago, as she says, or even at a still earlier period. Still, her general condition is not very bad, and the cause of the few symptoms of which she complains became at once apparent when a physical exploration was made. The woman lying on her back, I passed my finger up into the vagina and found the

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## MEDICAL SOCIETIES.

## COLLEGE OF PHYSICIANS OF PHILADELPHIA.

## Does Excision of the Larynx Tend to the Prolongation of Life?

BY J. SOLIS COHEN, M. D.,

Honorary Professor of Laryngology in Jefferson Medical College.

[Read April 4, 1883.]

That complete laryngectomy can be performed without sacrifice of life, there is now accumulative evidence.

That every operation involving the removal of the larynx imperils the immediate existence of the patient, the records of the procedure abundantly attest.

That a very large proportion of the subjects operated upon, say nearly fifty per cent. of them, succumb within so brief a period that their deaths may be justly attributed to the operation, an examination into its statistics renders only too obvious.

The writer owns to a prejudice against the operation; he has never witnessed a laryngectomy, nor seen a patient upon whom it had been performed. It may seem rather an assumption on his part, therefore, to criticize an operation, of the technical procedure and after management of which he is practically ignorant.

Let us consult the statistics of the operation, and contrast the average life of those who have been subjected to it, with the average life of patients in similar condition, entrusted to palliative treatment.

I have before me, as I write, more or less detailed records of sixty-five operations of complete "extirpation of the larynx," as it is termed.

There are a number of partial excisions, which have not been brought into the subjoined table because the partial operation is not included in the scope of this paper.

Of the above sixty-five complete operations, four were performed in non-malignant cases; one for cicatricial syphilitic stenosis, with death "some weeks after from pneumonia" (Case 1) [Watson]; one for necrosis, the case terminating fatally by marasmus five days after the operation (Case 22) [Rubio]; one for polypi of the larynx (Case 64) [Ruggi]; and one for papilloma of the larynx (Case 65) [McLeod].

Of the sixty-one operations remaining in this list, five were performed for sarcoma; in two of which the results were so remarkably exceptional, that attention should be especially directed to them.

I. Bottini, of Turin, on February 6, 1875, removed the entire larynx from a male subject twenty-four years of age, with a laryngeal sarcoma, partly round-celled, partly spindle-celled. Notwithstanding copious hemorrhage and severe erysipelas, the patient recovered. He was reported well in August, 1881, or more than six years after the operation, and I have seen no notice of his death. He had been performing the duties of a postman, and walking eight miles a day. This is the most successful case on record.

II. Caselli, of Reggio-Emilia, on September 20, 1879, removed the larynx, pharynx, base of the

uterus quite high up. By means of conjoined manipulation I ascertained that it was about the size which we could expect to find at the patient's time of life; but to the left of the uterus there was a large hard mass in the position where she feels the fluttering sensation of which she has spoken, and which annoys her so greatly. This I made out to be about the size of a cocoanut, and then on the right side of the uterus I found another similar mass, though of smaller size; while peeping up from behind the body of the uterus there was still another one. Here, then, was undoubtedly the diagnosis, uterine fibroids, and I now represent for you on the blackboard the relative size and positions of the three tumors.

Originally, these fibroids were, perhaps, situated in the structure of the uterine walls; and if this was the case, they no doubt set up an endometritis, the ichorous discharge resulting from which may possibly have destroyed the vitality of the spermatozoa with which it came in contact, and so prevented the occurrence of pregnancy.

Why should this patient experience shortness of breath? Simply because the condition present in her case is almost invariably accompanied by a depreciated state of blood. After the menopause, uterine fibroids never increase in size. On the contrary, they gradually become more and more atrophied, and during the last five months these tumors have, no doubt, been diminishing in size. The reason that she has felt worse of late is, probably, due to the fact that she is suffering from the results of a prolonged impoverished condition of the system, which has become more serious as time went on. But, it may be asked, may not these tumors possibly grow still? Yes, it is altogether possible, although it would render the case an exceptional one. For instance, the growth on the left of the uterus might become sarcomatous, the one on the right might become cystic, and so change to a fibro-cystic tumor, while the one behind might become carcinomatous. Under these circumstances they would probably increase in size, but they would have changed their character completely, and would no longer be simple fibroids. In the earlier part of the course you will, perhaps, remember that I told you of a large tumor which I removed at the Woman's Hospital from a patient who was long past the menopause, and which was pronounced by one of the most accomplished microscopists in the city to be of a fibroid character. I am thoroughly convinced in my own mind, however, that the microscopist is mistaken, and for the reason that in all my experience I have never known or heard of a fibroid tumor existing in a state of vitality after the final cessation of the menses. I believe that the growth was really of a sarcomatous nature at the time that it was removed, whatever may have been its character at an earlier period of the patient's life. In the present case, the time for local treatment (should any have been desirable previously) is now passed. The woman is simply a candidate for general treatment, and what she needs is tonics, good food, and plenty of fresh air.

—The Illinois Training-school for Nurses is having built, near Cook County Hospital, a Home for a residence for its nurses. The necessary funds have been contributed by the public.

TABLE I.—LIST OF COMPLETE LARYNGECTOMIES, INCLUDING AND SUPPLEMENTING THE TABLES OF MACKENZIE, FOULIS, BLUM, AND BROW.

No.	Operator.	Date.	Age Sex	Disease.	Parts Removed.	Result.	Reference.	Remarks.
1	Watson, Patrick Heron (of Edinburgh).	1866	36 M.	Stenosis from syphilis.	Larynx and one ring of trachea.	Death in 3 weeks from pneumonia.	Foulis: Transactions International Medical Congress, Aug. 1881, vol. iii, p. 255.	Pneumonia was suspected before the operation.
2	Billroth (Vienna).	1873 Dec. 31	36 M.	Carcinoma of the larynx.	Larynx, lower third of the epiglottis, part of the upper two rings of the trachea.	Death from recurrence 7 mos. after the operation.	Archiv. f. klin. Chirurgie, Bd. xvii., H. ii., p. 343.	Recurrence noted at end of four months.
3	Heine (Prague).	1874 Apl. 28	59 M.	Carcinoma of the larynx.	Entire larynx.	Death from recurrence 6 mos. after operation.	Arch. f. klin. Chir., Bd. xix., p. 584; Böhm. Corresp. Bl., 1874.	
4	Schmidt, M. (Frankfort).	1874 Aug. 12	56 M.	Epithelioma of the larynx.	Thyroid, cricoid, and both arytenoid cartilages.	Death on fourth day from collapse.	Arch. f. klin. Chir., Bd. xviii., H. i., p. 189.	
5	Maas (Breslau).	1874 June 1	57 M.	"Adeno-fibroma carcinomatous."	Entire larynx.	Death from pneumonia 2 weeks after operation. "On fourth day," <i>Zitum</i> .	Arch. f. klin. Chir., Bd. xix., p. 507.	
6	Watson, P. H. (Edinburgh).	1874	60 M.	Epithelioma of larynx extending to the left vocal band.	Larynx.	Death from pneumonia in 2 weeks.	Foulis, Trans. Int. Medical Congress, 1881.	
7	Schönborn (Königsberg).	1875 Jan. 22	72 M.	Carcinoma of the larynx.	Entire larynx.	Death on the fourth day.	Berliner Klin. Woch., Sept. 20, 1875, p. 225.	
8	Botini (Turin).	1875 Feb. 6	24 M.	Sarcoma (partly rounded, partly spindle-celled) of the larynx.	Entire larynx.	Well. April 19, 1881, probably still alive.	Comunicazione letta Jun. 21, la R. Accademia di Medicina di Torino, April 30, 1875. Letter from Prof. Bottini to Dr. Foulis.	The operation entailed copious hemorrhage, and was followed by severe erysipelas.
9	Langenbeck (Berlin).	1875 July 21	57 M.	Carcinoma of upper part of larynx, of the epiglottis, and of the hyoid bone.	Entire larynx, hyoid bone, part of the tongue, pharynx, and esophagus.	Death from recurrence in cervical lymphatic glands 4 months after.	Berlin klin. Woch., 1875, No. 33, p. 433; Arch. f. klin. Chir., Bd. xxi., Supplement, p. 136.	
10	Multanowski (St. Petersburg).	1875 July 27	59 M.	Carcinoma.	Entire larynx.	Death from croupous pneumonia 3 months after operation.	Centbl. f. Chir., 1882, No. 36, and letter from Dr. A. Schmidt to Prof. Burow (Arch. Laryng., N. Y., April, 1883).	
11	Multanowski (St. Petersburg).	1875 Aug. 9	47 M.	Carcinoma.	Entire larynx.	Death from recurrence 2 mos. after operation.	As above.	Head not been preceded by tracheotomy; wound did well, with but little febrile reaction.
12	Billroth (Vienna).	1875 Nov. 11	54 M.	Diffuse carcinoma of the larynx.	Entire larynx.	Death on the fourth day from extensive broncho-pneumonia.	Billroth's Clinical Surgery, London, 1881, p. 133.	Recurrence in posterior portion of tongue about 3 months after operation. Death by hemorrhage from the ulcerated mass.
13	Maas (Freiburg).	1876 Feb. 5	50 M.	Epithelioma of the larynx.	Entire larynx, with exception of the epiglottis and of a small piece of cricoid cartilage.	Death from recurrence 6 mos. after the operation.	Arch. f. klin. Chir., Bd. xx., p. 535. Private communication from operator to Dr. Foulis, Trans. Int. Med. C., London, 1881.	
14	Gerdes (Jever).	1876 Mar. 30	76 M.	Carcinoma.	Entire larynx.	Death on the fourth day from collapse.	Arch. f. klin. Chir., Bd. xxi., H. ii., p. 473.	
15	Reyher (Dorpat).	1876 May	60 M.	Carcinoma of the vocal bands.	Entire larynx, with exception of epiglottis.	Death on the eleventh day from hyposstatic pneumonia.	St. Petersburg Med. Woch., 1877, Nos. 17 and 18.	
16	Watson, P. H. (Edinburgh).	1876	60 F.	Epithelioma of larynx, with extension of some adjacent glands.	Larynx and enlarged glands.	Death in one week from pulmonary embolism.	Letter from operator to Dr. Foulis.	
17	Koslowski (Warsaw).	1877 Mar. 31	33 F.	Epithelioma of the larynx, with perforation of the skin.	Entire larynx.	Death from recurrence 9 mos. after operation.	Centbl. f. Chir., 1877, No. xxvi., p. 491. Private communication from operator to Dr. Foulis.	The lingual and facial veins were cut in the operation.

TABLE I.—Continued.

No.	Operator.	Date.	Age Sex.	Disease.	Parts removed.	Result.	Reference.	Remarks.
18	Foulis (Glasgow).	1877	28 M.	Sarcoma. "partly papillary."	Entire larynx, with ex-	Death from tracheal and pulmonary.	Lancet, Oct. 13, 1877, and Mar.	

TABLE I.—Continued.

No.	Operator.	Date.	Age Sex.	Disease.	Parts removed.	Result.	Reference.	Remarks.
18	Foulls (Glasgow).	1877 Sept. 10	M.	Sarcoma, "partly papilloma, partly spindle-celled carcinoma."	Entire larynx, with excision of superior cornua of thyroid cartilage and the arytenoid cartilages.	Death from tracheal and pulmonary phthisis, March 1, 1878.	Lancet, Oct. 13, 1877, and Mar. 29, 1879.	
19	Wegner (Berlin).	1877 Sept. 16	F.	Carcinoma of the larynx, size of walnut, originating from right ventricle of larynx.	Entire larynx, with epiglottis, but leaving lower half of the cricoid cartilage.	Well April 12, 1878.	Verh. der Deutschen Gesellsch. f. Chir., 1878. Private communication from operator to Dr. Foulls.	Performed "bloodlessly," with galvano-cautery blade.
20	Bottini (Turin).	1877 Aug. 29	M.	Epithelioma of the larynx.	Entire larynx and portion of esophagus.	Death on the third day from double pneumonia.	Annales des maladies de l'oreille et du larynx, July 1, 1878; Centbl. f. Chir., 1878.	Preliminary tracheotomy not performed. Collapse after operation, and hyperpyrexia for a week. Voice tube employed in five weeks.
21	Bruns, Victor von (Tubingen).	1878 Jan. 29	M.	Epithelioma of the larynx (of 5 years' duration).	Entire larynx.	Death from recurrence 9 mos. after operation.	Wien. Med. Presse, Nov. 17, 1878. Communication from Prof. Paul Bruns to Dr. Foulls.	
22	Rubio (Madrid).	1878 May 11	M.	Perichondritis of the thyroid cartilage, with necrosis.	Entire larynx.	Death on the fifth day from marasmus.	Observation clinique, etc. Real Academia, de Med., Madrid, 1878.	
23	Czerny (Heidelberg).	1878 Aug. 24	M.	Sarcoma in and under vocal bands, and perforating the thyroid cartilage; also involving the neighboring glands.	Entire larynx and the diseased glands.	Death 15 months after operation (as the result of a new operation?).	Letter from operator to Dr. Foulls, Schuller, die Tracheotomie, Billroth and Lücke's Deutsche Chirurgie, 1880, p. 200.	Repeated removals of recurring masses.
24	Billroth (Vienna).	1879 Feb. 27	F.	Epithelioma of pharynx, larynx, and thyroid gland.	Entire larynx, with part of pharynx and esophagus.	Death during seventh week from passage of bougie into mediastinum.	Private communication from operator to Dr. Foulls.	
25	Guseinbauer (Prague).	1879 May 24	M.	Carcinoma.	Entire larynx.	Death 2 months after operation from tuberculosis pulmonum.	Letter from operator to Prof. Burow, Arch. Lar., April, 1883.	
26	Macawen, Wm. (Glasgow).	1879 July 31	M.	Carcinoma of larynx and upper end of gullet; also a glandular mass at base of larynx.	Larynx, part of gullet, and glandular mass.	Death in 3 days from pneumonia.	Foulls, Trans. Int. Med. Con., London, 1881.	
27	Caselli Azzio (Reggio Emilia).	1879 Sept. 20	F.	Sarcoma of larynx, pharynx, palate, and base of tongue.	Entire larynx, pharynx, base of tongue, soft palate and tonsils.	Well August, 1881 (probably still living).	Bul. del Scien. Med. Bologna, 1880, vol. v.; Centbl. f. Chir., 1880; Caselli's Reprint, Bologna, 1880. Caselli's statement at meeting Int. Med. Con., London, 1881. Archives of Laryngology, N. Y., 1879, p. 36.	Operation occupied more than 3 hours, was largely done with the galvano caustic blade, and was attended with but little hemorrhage.
28	Lange, F. (New York).	1879 Oct. 12	M.	Sarcoma of larynx involving the gullet.	Larynx, right cornua of hyoid bone, part of gullet.	Death from ashenia nearly 7 months after operation. Recurrence.	Centrabl. f. Chir., 1882, No. 25. Letter from Dr. A. Schmidt to Prof. Burow, Arch. Lar., April, 1883.	
29	Multanowski (St. Petersburg).	1879 Dec. 4	M.	Carcinoma.	Entire larynx.	Death on fifth day from pneumonia.		
30	Langenbuch.	1879	An aged female.	.....	.....	Death on third day from colic.	Verh. der Deutschen Ges. f. Chir., Bd. x.	Only met by compiler in Han's Hist. Arch. Gen. de Med., 1882, II., p. 79.
31	Reyher, Carl (St. Petersburg).	1880	M.	Carcinoma.	Larynx.	Death on seventh day from septic broncho-pneumonia.	Wolner's, Med. Jour., 1880, H. Letter from operator to Dr. Foulls.	

TABLE I.—Continued.

No.	Operator.	Date.	Age Sex.	Disease.	Parts removed.	Result.	Reference.	Remarks.
32	Thiersch (Leipzig).	1880 Feb. 26	36 M.	Carcinoma.	Entire larynx and two rings of trachea.	WELL 18 MONTHS AFTER OPERATION.	Deutsch. Ztschr. f. Chir., 1881, p. 149. Centbl. f. med. Wiss., Sept. 23, 1882. Revue mens. de Larynx, No. 82, p. 350, but accredited to Landerer.	Tracheotomy, Sept. 27, 1879. Laryngotomy for access to growths, Feb. 3, 1880.
33	Thiersch (Leipzig).	1880 Apr. 15	52 M.	Carcinoma.	Entire larynx.	WELL 27 MONTHS AFTER OPERATION.	As above.	Tracheotomy, Mar. 2, 1880.
34	Czerny (Heidelberg).	1880 Oct. 11	47 M.	Epithelioma of larynx and suprajacent soft parts.	Larynx and soft tissues in front of it.	Death from exhaustion and hemorrhage (March 25, 1881) after.	Letter from operator to Dr. Foulis.	
35	Hahn (Berlin).	1880 Oct. 23	67 M.	Carcinoma.	Larynx, all except a portion of the thyroid cartilage.	FREE FROM RECURRENCE 2 YEARS AFTER OPERATION.	Letter from operator to Prof. Burw. Archives of Laryngology, April, 1883.	
36	Thiersch (Leipzig).	1880 Nov. 10	45 F.	Carcinoma of pharynx and larynx.	Larynx and part of pharynx.	Death from recurrence in 4 months (March 16, 1881).	Deutsch. Ztschr. f. Chir., 1881, xvi, p. 149.	Tracheotomy, Oct. 17, 1883. Recurrence noted within 6 weeks after operation.
37	Bircher, H. (Aarau).	1880 Dec. 3	49 F.	Scirrhous of the thyroid gland, involving the larynx.	Thyroid gland excised; 6 months later the cancer recurred, and the larynx was excised with part of the gullet.	Death in 16 days from pneumonia and gangrene of the lung.	Letter from operator to Dr. Foulis. Trans. Int. Med. Congress, 1881.	
38	Pick (London).	1881 Jan. 16	39 M.	Epithelioma of larynx (preceded by papilloma).	Larynx and epiglottis.	Death in 5 days from pleurisy and pericarditis.	Lancet, April 2, 1881, p. 541; Brit. Med. Jour., April 9, 1881, p. 562.	
39	Thiersch (Leipzig).	1881 Jan. 17	57 F.	Carcinoma of pharynx and larynx.	Entire larynx and part of pharynx.	Death on seventh day from secondary infectious pneumonia.	Deutsch. Ztschr. f. Chir., 1881, Bd. xvi, p. 149.	Tracheotomy, Dec. 9, 1880.
40	Toro (Cadiz).	1881 March 9		Epithelioma of larynx.	Hyoid bone, base of tongue, and larynx.	Death on fourth day from pulmonary emphysema.	Med Record, N. Y., August 6, 1881, p. 167.	
41	Winlaw (Liege).	1881 April	55 F.	Carcinoma.	Entire larynx.	NO RECURRENCE 11 MONTHS AFTER OPERATION.	Clinique Chir. Univ. Liege; Monatschr. f. Ohrenheilk., 1882, No. 9. Burw's list.	
42	Foulis (Glasgow).	1881 April 30	50 M.	Epithelioma of larynx (preceded by papilloma).	Larynx.	Well and strong, August, 1881.	Brit. Med. Jour., May 7, June 11, 1881; Trans. Int. Med. Congress, London, 1881.	
43	Czerny (Heidelberg).	1881 May 12	47 M.	Epithelioma.	Larynx and upper two rings of trachea.	Well and strong, August, 1881.	Letter from operator to Dr. Foulis. Verbal report to Int. Med. Cong., London, 1881.	
44	Reyher, Carl (St. Petersburg).	1881 May 14	57 M.	Carcinoma.	Larynx.	Death on fifth day from septic broncho-pneumonia.	Letter from operator to Dr. Foulis. Trans. Inter. Med. Congress, 1881.	
45	Kocher (Berne).	1881 May 16	59 M.	Carcinoma.	Entire larynx, except a piece of the cricoid cartilage.	NO RECURRENCE 16 MONTHS AFTER OPERATION.	Letter from operator to Prof. Burw. Arch. Larynx, N. Y., April, 1883.	Patient wears a self-made artificial epiglottis to overcome choking in deglutition, result of exclusion of epiglottis.
46	Tilanus (Amsterdam).	1881 May	51 M.	Epithelioma.	Entire larynx.	Death in 36 hours from colic.	Centbl. f. Chir., 1882, No. 34.	
47	Gussenbauer (Prague).	1881 May 19	48 M.	Carcinoma.	Entire larynx.	WELL 19 MONTHS AFTER OPERATION; doing duty as a riding master.	Letter from operator to Prof. Burw. Arch. Larynx, N. Y., April, 1883.	
48	Volker (Brunswick).	1881 May 28	44 F.	Carcinoma epithelioides.	Entire larynx.	Death from suffocation five months after operation.	Academisch Proefschrift, Amsterdam, 1882, pp. 84 and 112.	Suffocated while patient had withdrawn canula to cleanse it.

TABLE I.—Continued.



TABLE I.—Continued.

No.	Operator.	Date.	Age Sex.	Disease.	Part removed.	Result.	Reference.	Remarks.
49	Albert (Vienna).	1881 July 6	45 M	Carcinoma almost filling right half of larynx.	Entire larynx, except epiglottis; also small section of adherent oesophagus.	Death on eighth day from diffuse bronchitis and lobular pneumonia.	Wien. med. Presse, 1881, xxii., p. 1373.	On 13th, hemorrhage from internal carotid, arrested by ligature above and below point of erosion. Collapse same evening; death next day.
50	Hahn (Berlin).	1881 Aug 13	46 M	Carcinoma.	Entire larynx.	Death in 25 days from putrid bronchitis.	Letter from operator to Prof. Burow.	Recurrence at end of 3 months.
51	Margary (Turin).	1881 Sept. 29	36 F	Epithelioma of oesophagus and larynx.	Larynx, first ring of trachea, thyroid body, part of pharynx, and oesophagus.	STRONG AND WELL 14 MOS. AFTER OPERATION.	Letter from operator to Prof. Burow.	
52	Gussenbauer (Prague)	1881 Oct.	62 M	Carcinoma.	Entire larynx.	Death from recurrence 9 mos. after operation.	St. Petersburg med. Ztschr., 1882, No. 28. Letter from operator to Prof. Burow.	
53	Reyher, Carl (St. Petersburg).	1881 Oct. 10	73 M	Carcinoma.	Larynx and upper three rings of trachea.	Death on seventh day from As above.	Glorn. di R. Acad. di Med. di Torino, vol. xxix, 1881, p. 38; Arch. Ital. di Lat., July 15, 1882.	
54	Reyher, Carl (St. Petersburg).	1881 Oct. 10	65 M	Carcinoma.	Larynx.	Recurrence in four months.	Deutsche Med. Woch., 1882, No. 33, p. 45.	
55	Novaro.	1881	63 M	Carcinoma.	Entire larynx.	Excision of right lobe of thyroid gland and part of pharynx on 11th day; patient died on 11th day. Two months later the patient was fitted with an artificial larynx.	Letter from operator to Prof. Burow.	Recurrence seven months after operation.
56	Schede.	1881	54 M	Carcinoid.	Larynx, hyoid bone, and thyroid gland.	Death 14 days after operation from exhaustion.	Wien. med. Presse, 1882, Nov. 4, 1882, p. 741.	
57	Reyher, Carl (St. Petersburg).	1882 April 7	55 M	Carcinoma epithelioides.	Entire larynx, pharynx, and parts of oesophagus.	WELL JANUARY 31, 1883. Probably still alive.	Lancet, dated Jan. 31, 1883.	
58	Kocher (Berne).	1882 May 13	54 M	Carcinoma.	Entire larynx and carcinomatous glands.			
59	Whitehead, Wm. (Manchester).	1882 May 27	46 M	Epithelioma of right vocal band and parts subjacent (as far down as upper portion of trachea).	Thyroid and cricoid cartilages and two rings of trachea, leaving epiglottis intact.			
60	Bergmann (Würzburg).	1882 June 12	54 M	Carcinoma (Adenoma sarcoma?).	Entire larynx.	SPEAKS WELL WITH ARTIFICIAL (BRUNS) LARYNX SOME MOS. AFTER OPERATION.	Sitzungsber. Würzburg. Phys. Gesell., 1882, 47-56. Deutsche med. Woch., 1882, No. 33; Centbl. f. Chir., Aug. 19, 1882.	
61	Burrow (Königsberg).	1882 July 7	44 M	Carcinoma.	Entire larynx without epiglottis.	Death from sudden suffocation 4½ mos. after operation.	Archives of Laryngology, April, 1883.	
62	Kocher (Berne).	1882 Sept. 28	43 M	Carcinoma.	Entire larynx and a portion of oesophagus.	No recurrence 3 mos. after operation.	Sammlung klin. Vorträge v. Volkman, No. 224, p. 1944.	
63	Maydl (Vienna).	1882	50 M	Carcinoma.	Larynx, except cricoid cartilage. Excision of a gland, size of a dove's egg.		Wien. med. Presse, 1882, xxii., 1672; Wien med. Woch., 1882, No. 44. Letter from operator to Prof. Burow.	
64	Ruggl.	1882	10 M	Polypi of the larynx.	Entire larynx.		Centbl. f. Chir., 1882, No. 45; Raccoglitore med., 1882, xviii., p. 36.	"Recovery in 28 days." Burrow's list.
65	McLeod (Calcutta).	1882	35 M	Papilloma of larynx.	Entire larynx and thyroid gland.	In good condition one month later.	Ind. Med. Gaz., 1883, xviii., 24-26.	

tongue, soft palate and tonsils, from a female subject nineteen years of age, for a sarcoma of the larynx, pharynx, palate and base of tongue. The patient was reported well in August, 1881, practically two years after the operation, and I have

seen no notice of her death. This is the second best case on record.

The remaining three patients operated upon for sarcoma, died at the periods of seven, fifteen, and seventeen-and-a-half months, respectively.

(To be Continued.)

## EDITORIAL DEPARTMENT.

### PERISCOPE.

#### A New Theory of Diphtheria.

The *London Med. Record*, April 15, 1883, says: "There is no creed in medicine. The freshest confirmation of this doctrine is to be found in certain recent original observations on diphtheria, which have led Dr. Woakes to describe this disease as a simple neurosis arising in persons deficient in tone, especially in vascular tone. It is by him considered to be in fact an atonic inflammation, and akin to a common cold in its theory of causation. The history of its production is thus to be read. The patient is in an exhausted nervous state (extremes of climate are particularly noted as accountable for this), and the vaso-motor control is consequently lowered. He is then exposed to some strong peripheral irritation or shock, *e. g.*, cold. The impression so produced is conveyed by the afferent fibres of the sympathetic in the pharyngeal mucous membrane to their central cells in the superior sympathetic ganglion, and through these exhausted centres produces a vaso-inhibitory action by means of the efferent sympathetic fibres going to the pharyngeal vessels, which under the circumstances is not soon replaced by a healthy tonic reaction. There is persistent local inflammation of low type.

The parietic muscular condition is similarly explained. The vaso-inhibitory action extends to those vessels which supply nerves, as the vagus (*vasa nervorum*), and receive their vaso-motor fibres from the centre originally impressed by the peripheral irritation. Hence pharyngeal muscular paralysis, and a heart soon exhausted by rapid action unqualified by vagal control.

The contagiousness of diphtheria is treated on a different hypothesis. The infective element is supposed to be a modified constituent of normal tissue—namely, a lymphoid cell. A layer of these has been described by Luschka as found in the mucous tissue of the pharynx. According to the new theory of diphtheria, these undergo abnormally rapid development in the inflammatory process, and, on being shed at the mucous surface, many—probably almost as soon as formed—become the infective particles of the diphtheritic membrane, and are capable of exciting in any suitable—*i. e.*, atonic raw or mucous surface—the train of changes to which they owe their morbid characters. There is a good deal in the history of diphtheria which gives support to the vaso-dilator view of its causation. Thus, it has been frequently observed that persons from some cause

enfeebled are readily affected by it; and common experience has shown that vaso-motor changes are particularly associated with a physique impaired by over-exertion or under-feeding—witness the drained constitutions which are the subjects of hysteria. Moreover, the occurrence of the disease sporadically, it would appear—in high and dry localities exposed to winds, and presumably well ventilated—suggests a climatic agency.

Moreover, the view of lymphoid cell contagion is in certain points allied to that which recognizes the action of specific disease germs, to which the communicability of diphtheria is now commonly ascribed. All these organisms alike belong to that low grade of vegeto-animal life which is characterized by the mutability of its forms, and no less by their apparently unlimited powers of self-propagation. Buchner held, with some reason, that the harmless hay-bacillus became, when bred in animal substances, identical with the highly infective bacillus of anthrax. The small-pox germ, conversely, has been found, on successive propagation through the cow, to become innocuous. The question may naturally suggest itself, Is it not possible for a lymphoid cell in a state of abnormal activity of growth to become a morbid excitant of over-sensitive tissues? Perhaps the strongest argument in support of this view is to be found in the phenomenon of "malignancy." No bacterial clue to this condition has been demonstrated; but, instead, the rapidly growing cell-elements of the parent tumor reproduce its like in distant parts, and even, according to Dr. Creighton, infect normal gland-cells so as to make them take on a morbid action.

But it must be remembered that the only part of the new diphtheritic theory which rests upon proof, is that which describes the process of local congestion, the method of the disease. This is simply a history of inflammation, and is characteristic of that change in other than the diphtheritic state. We do not deny that apparently simple sore-throats found in the same house with diphtheria are suggestive of a common origin; but the concurrence is explicable on other theories than the purely vaso-motor, and we require to have it shown why, if atony and exposure constitute the causes of diphtheria, most feeble persons who have tonsillitic throats from exposure do not exhibit the other symptoms and characteristic sequelæ of that disease.

With regard to the lymphoid element of contagion and its effects on tissues favorable to its development, proof is wanting. No doubt the mucous tissue abounds in such elements, but the

presence of bacilli and spores, especially in diseased states, has also been often demonstrated. By which of these means is the disease propagated? Which is the essential irritant of afferent nerve-fibres? In other infective diseases, as tubercle and anthrax, recent observation has shown beyond doubt that this power resides in the bacilli; and though investigation has not proceeded so far in regard to the exanthemata of diphtheria, still the persistence of specific peculiarities in each of these disorders, the transference of these unchanged from subject to subject, and the want of clear proof of the existence of hybrid diseases, support the view that in every such infective morbid state the essential agent is a special foreign germ, able to bring about in the animal body its own peculiar pathological state. How far this germ owes its characters to its habitat, and communicates a condition of which it is itself the subject rather than the primary cause, remains still open to question.

The means of contagion is therefore the point which has still to be settled in regard to diphtheria; and so far, we must admit that the bulk of evidence goes to show that this consists in some form of bacterium. Neurotic influence is the admitted method by which any form of germ can produce its local manifestations; but it has not yet been shown to be in diphtheria more than the mode of action of an undetermined cause.

#### Sub-Periosteal Hemorrhage of Long Bones in a Rickety Infant.

In the *Medical Times and Gazette*, April 7, 1883, Dr. Herbert W. Page records the case of an infant, aged nine months, extremely wasted, pale and ill, who was sent to him by Dr. Taylor, of Willesden, and who presented enormous enlargement of the shafts of the left femur and tibia, and of the upper third of the right tibia also. The swelling had been coming on and gradually increasing for about a month. The neighboring joints were not affected, and there was no superficial sign of inflammation. Beading of the ribs and rickety enlargement of one radius led to the belief that the condition was in some way due to rickets, and this supposition was also based on the fact that the child had from birth been fed for three weeks on Swiss milk, and after that almost entirely on Nestlé's and Savory's foods. There was no history of syphilis, and in the absence of general fluctuation no certain diagnosis was made. A trocar and canula passed at one point in the thigh, where there was doubtful fluctuation, gave exit to a few drops of sanguineous fluid, the bone being found bare. Incisions were therefore made through the periosteum of both thigh and leg, and large blood-clots, which had to be broken up with the finger before any part of them could be removed, were found lying around the shafts, the periosteum being stripped up therefrom throughout their entire length. Being now properly fed, the child, whose recovery had seemed well-nigh hopeless, began at once to improve; the blood-clots were gradually expelled, there was little or no suppurative, the wounds healed; and when seen three months afterwards, the affected bones had resumed their normal size, and the periosteum its natural position in contact with the shafts. There is no hemorrhagic diathesis in the family. The author refers

to the difficulties in diagnosis presented by this case, especially in the absence of fluctuation, which was doubtless due to blood-clot being tightly packed between periosteum and bone. He is now inclined to regard the disease as scorbutic rather than rickety, and the hæmorrhage as the more essential element of the pathological condition than inflammation of the periosteum. The child had been reared on scurvy diet. Periostitis is almost unknown, even in the worst cases of rickets. There was no sign of inflammation either in the neighboring joints or in the skin, and it is, moreover, noteworthy that both periosteum and bones have survived the attack. Such could hardly have been the issue of an acute hæmorrhagic periostitis, even though the hæmorrhage, as a local blood-letting, might have conduced to the safety of the periosteum. He refers to other cases, of which, indeed, there is only one definite example on record, in support of this doctrine. A case was recorded by Mr. Thomas Smith in vol. xxvii. of the *Pathological Society's Transactions* as "Hæmorrhagic Periostitis of the Shafts of Several Long Bones, with Separation of Epiphyses," where after death the shafts were found surrounded by blood-clots underneath the periosteum, and in which there were numerous hæmorrhages in the muscles also, with a large hæmorrhage in one lung—hæmorrhages, in fact, like those ordinarily seen in scurvy. In one of three cases recorded by Dr. Cheadle of "Scurvy Supervening on Rickets in Young Children," in addition to bleeding gums, and other usual signs of scurvy, there were "hard swellings deeply seated in the flesh of each thigh, and the shafts of the long bones felt enlarged and swollen." The author has little doubt that in that case also the enlargement was due to subperiosteal hæmorrhage. The child had been fed on a scurvy diet, and the state of the gums very clearly told what unnatural agents had been at work. In his own case the diet was a distinctly scurvy diet, lacking every kind of fresh food, and he trusts that the record of it may lead to a surer diagnosis and better treatment in other cases, where the absence of swollen and bleeding gums deprives us of an all-important clue to the nature of the malady.

#### Snake Poisoning.

We note the following from the *Lancet*, April 21, 1883:

A paper by Dr. Baddaloni, on "Permanganate of Potash as an Antidote to Viper Poison," was read at the Medical Society of London on Monday last. It related experiments conducted to test the truth of Lacerda's assertion that permanganate of potash is both a chemical and a physiological antidote to viperine, the active principle of viper poison. He has failed to obtain any evidence in support of the latter part of this assertion. Prince Lucien Buonaparte—whose chemical investigations into viper poison first established the fact of the existence of a special active principle, which he named "viperine"—was present and spoke, referring to the great need there is of investigation into the chemical change produced in the blood by viperine, a change which destroys its power of coagulability. Sir Joseph Fayrer fully admitted that permanganate of potash is a chemical antidote to viperine, though not a physiological one;

but he thought it might be of use as a local application to snake bites, after means had been taken to prevent absorption of the poison into the general system; in fact, as a substitute for excision and cauterization of the part. He referred to the marked difference in the physiological effects of the poison of the viperine and colubrine snakes—the former being less intense and preventing coagulation of the blood, the latter more rapid and intense, and not interfering with the coagulability of the blood. He doubted the possibility of ever finding a true physiological antidote to snake poison that would be effectual if introduced into the body after the poison had once passed into the general circulation. Sir Joseph Fayrer was able to add many interesting and valuable facts from his own experience, and in reply to a question from Dr. John Ogle gave a caution about the popular belief in the safety and efficacy of sucking a snake bite. He stated that the poison is absorbed even through an entire unabraded mucous membrane, and he doubted whether it is possible to extract by suction anything more than a very minute proportion of the poison introduced in the tiny puncture made by the poison fang of a snake.

#### Imperforate Anus.

Dr. B. W. Hinds reports this case in the *Southern Practitioner*, June, 1883:

The child had been born 56 hours, and in consequence of the long time which had elapsed, was in great pain. I made a careful examination, exploring the parts carefully, satisfying myself that I could discover vestiges of an opening through the expanded sphincter, circular in form, and about the proper distance between the scrotum and coccyx for the anus. I proceeded at once to operate, and selecting from my pocket case such instruments as I thought necessary: placing the child in the lithotomy position, an assistant holding it firmly, I made an incision five-eighths of an inch long, with an ordinary bistoury, along the raphéal line. I then took a probe-pointed bistoury, with which I made a cross incision of about the same length as the one first made, completing the operation. To my great satisfaction the meconium passed immediately, giving me full assurance of the fact that my operation was thus far successful. After the bowels had acted sufficiently, I applied a pledget of lint with compress and bandage, and retired for the night, giving instructions to the nurse to watch for hemorrhage; but she got careless during the night, let the bandage get off, the compress fell away, and hemorrhage took place to an alarming extent; which, when I awoke, I stopped immediately by the application of a new bandage and compress, saturated with alum. There being only a tegumentary covering, reducing the malformation to the simplest variety, the treatment was necessarily simple. Every day for three consecutive days, I opened the orifice with a large silver catheter, following it in a short while with a slippery-elm bougie made from the bark fresh cut from the tree, letting it remain *in situ* for 20 or 30 minutes each time. This constituted the entire treatment. The child recovered with a perfect anus, the sphincters contracting naturally. There is nothing peculiar about this case of which I am

aware, except that the raphéal line extended all the way from the scrotum to the os coccyx. There was one artery, a branch of the perineal, running longitudinally with the raphé, that I think was inordinately large.

#### Apomorphia a Safe, Certain, and Quick Emetic.

In the *Brit. Med. Jour.*, May 5, 1883, Mr. Brown, L. R. C. P., of Bacup, writes:

It has occurred to me, in several cases, to have patients who have been obnoxious to ordinary emetics. The emetic has caused nausea and depression, but no emesis. A few weeks ago two cases of this kind occurred in my practice. One was a man who had been drinking and eating indigestible food. Domestic emetics were given, which had produced nausea and ineffectual attempts at vomiting. It occurred to me that apomorphia, used hypodermically, might succeed. I prepared a solution containing a grain of chloride of apomorphia, twenty minims of rectified spirit, and water to two drachms, of which I administered ten minims hypodermically, which equals one-twelfth of a grain. In seven minutes, it produced free and copious vomiting. There was no nausea, nor depression, nor intolerance of food. The other case was a man who was a total abstainer. Patient had loaded his stomach with a mass of indigestible food, which had caused acute pain in his stomach. He had tried domestic remedies without success. Pain was so severe that I was called up at night. The other case having been so successful, I at once administered ten minims of the solution. In two minutes, without any previous nausea or warning, the contents of the stomach were violently ejected on the floor, the patient not having time to get a vessel to vomit into. This was repeated two or three times at short intervals, and the patient had speedy relief. In this case there was no nausea or bad after-effect.

From inquiries which I have made, I am convinced that the value of apomorphia as a safe, certain, and quick emetic is not appreciated, because not known. In cases of alcoholic and narcotic poisoning, it is a most valuable remedy; and, judging from my experience in one case, the emesis is delayed but a few minutes. In cases of acute gastralgia and convulsions in children, due to overloaded stomach, apomorphia will prove a speedy cure. I have given one-sixth of a grain of the drug to children by the mouth without producing any effect whatever.

#### Transient Paralysis in Association with Partial Epilepsy.

From the *Medical Times and Gazette*, April 21, 1883, we learn that some very carefully investigated cases of this association are to be found in the *Revue de Médecine* for March, recorded by M. Dutil. The class of cases referred to are those which are familiar to us in this country from the writings of Dr. Hughlings-Jackson, where a person has a convulsive seizure localized to one side of the face, or one or both limbs on the same side of the body, followed by a transitory loss of power in the part convulsed, the loss of power lasting from a few minutes to a day or two. It is important not to confound this class of cases with those where a permanent hemiplegia is associated



with attacks of partial epilepsy, such being always cases of destructive brain-lesion within the motor area. The group of cases under consideration do not result from a lesion in the motor area; they may be due to lesion somewhere in the neighborhood of the motor area, or even to a peripheral lesion. M. Dutil accepts Dr. Hughlings-Jackson's view that the paralysis in these cases is due to temporary local exhaustion of that portion of the brain which has been the seat of the discharging lesion; but, curiously enough, he does not see his way to applying the same reasoning to ordinary cases of epilepsy, and refuses to consider the state of complete resolution which supervenes on an epileptic seizure as a total paralysis. The practical point to be gathered from this study—and it is a very important one—is, that if a person dies with some paralysis not long after a convulsion, and no gross lesion of the brain is found, we are not to conclude that there is no truth in the doctrine of cerebral localization, as the case may be one of partial epilepsy. We cannot help thinking that a good many of the cases recorded by the older writers, which have been quoted as proof of the non-existence of any special motor regions in the brain, would probably receive a correct interpretation by being classed as cases of partial epilepsy associated with transient paralysis.

#### A New Tongue-Depressor.

Dr. N. Thornton Parker, Acting Assistant Surgeon, U. S. A. describes this instrument in the *Boston M. and S. Jour.*, May 10, 1883:

It is a matter of very general complaint that most of the tongue-depressors now in use are clumsy and heavy for the operator, and needlessly disagreeable for the patient. Their form is also an obstacle to their cleanliness. Many of them are even dangerous, and capable of conveying disease. I would therefore recommend the new tongue-depressor made for me by Messrs. Codman & Shurtleff, of Boston, Mass., which I think is very much more desirable than those already in use. It is made of wire, nickel plated, the size used in Sims' (wire) speculum for general use, and of smaller wire for use with children. It is light and capable of being readily cleansed, is convenient for the operator, and not disagreeable to the patient. It is held in the right hand between the thumb and forefinger, the second finger between the wires, and the last two fingers to the right of the instrument. The motion is made by the closing of the fingers, and no force is required, only gentle pressure with a slight drawing forwards.



#### Diseases of Pre-historic Men.

Gaillard's *Medical Journal*, April 21, 1883, says that this subject has received some attention in a paper read by M. Le Baron (*Thèse de Paris*, 1881),

before the Anthropological Society of Paris. Dr. Knapp, of New York, has also (*Archives of Otology*) studied the mound-builders from the standpoint of otology. As the result of an examination of two hundred and fifty skulls of the mound-builders, he found exostosis in forty-four cases. The condition was due to the habit of carrying foreign bodies in the meatus auditorius. Neither of these papers, however, compared in scope with that of W. H. Jackson, M. R. C. S., read before the West Kent (England) Medico-Chirurgical Society. He (*Athenæum*) cited a case of exostosis in a femur found at Lozère; evidence of toothache and abscesses in the jaw found there and in the Belgian bone caves; of rheumatic ulceration of the joint in a jaw-bone and an astragalus from Furfooz, Belgium, and in other instances; a case of very extensive inflammation from the Caverne de l'Homme Mort, Lozère; a case of hydrocephaly from the Trou Rosette, Belgium, and one from the Canary Isles, observed by M. Verneau; hemiplegia in the skeleton found at Cissbury, Sussex; hip-joint disease in four cases recorded by M. Le Baron; synostosis of the sutures in the Neanderthal skull; and numerous cases of surgical and posthumous trepanation. He also expressed the opinion that syphilis is a pre-historic disease, citing examples of it from Bray-sur-Seine, in France, from Patagonia, and from Peru, and hazarded the suggestion that circumcision, which prevails in every division of the globe, and is almost universally performed with a stone implement, is a practice which has descended from pre-historic times. Flattening of the skull is known to have been practiced, and fractures of bones and wounds of the skull are, of course, very frequent. Upon the whole, it may be concluded that the diseases of neolithic pre-historic man did not differ much from those of the present day.

#### The Brand Treatment of Typhoid Fever.

From the *Medical Press*, April 11, 1883, we learn that at the Académie de Médecine M. Peter made a vigorous attack on the Brand treatment of typhoid fever, which he styled as brutal and dangerous. The cold bath not only affected the temperature, but had a well-recognized deleterious action on the whole organism. So much was refrigeration coming into fashion, that he would not be surprised if some fine day a machine was made with a thermometer at one end and a pair of clamps at the other, which, when the thermometer should attain a certain degree, would, by automatic action, seize the patient and place him in a bath ready prepared! As to the statistics given by his German *confrère*, he considered they were not exact; for the Lyons medical staff, who had adopted the Brand treatment, very generally reported that, under the cold bath treatment, the mortality rose two per cent. above the average. Referring to M. Pasteur and his recent discovery of the mode of propagation of contagious diseases, that is to say, by a microbe peculiar to each disease, M. Peter considered it to be an entirely new doctrine for him; yet he was inclined to believe it. But the next thing in his opinion was to find a parasiticide for each microbe, and as such he would suggest camphor, as having a less disagreeable odor than phenic acid.

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#### CHLOROFORM-NARCOSIS.

Surgeons seem to abstain more and more from the administration of chloroform as an anæsthetic during operations. So many fatal accidents have occurred under its use, so frequently has death taken place suddenly and under circumstances which it took all the ingenuity of the best medical minds to explain, so various and almost incalculable are the conditions, under which chloroform suddenly extinguishes life: sometimes at the very beginning of narcosis, before one hardly can speak of overdosing of the nervous centres—then, again, under deep narcosis, the individual either suffering from organic disease of heart or lung, or having no such lesion—occasionally, long after the withdrawal of the drug—that we cannot wonder at one eminent surgeon after another turning his attention to some other less dangerous anæsthetic. At the same time, the fact cannot be denied that some of the most experienced surgeons of this country and Europe have for a very long period of years never employed any other anæsthetic than chloroform, and have never met with a fatal case, where death could have been ascribed to this remedy. This would seem to prove, that if the chloroform is pure, if it is correctly administered, and if given to selected cases, or, with fewer words, if the necessary precautions are taken, the drug, by itself, will never cause death. We must remember, also, that some of the greatest achievements of modern surgery are due to chloroform, and that we in reality do not possess as yet a substitute for the latter, always as reliable, always as effective.

The whole question is undoubtedly a very interesting one, and any information tending to throw light upon it, should be welcome.

France is to-day, perhaps, the only country where chloroform is still generally employed by the majority of surgeons, but that there a similar agitation against the use of this anæsthetic is now taking place, can be seen from a very animated discussion which, during the month of December of last year, was held in l'Académie de Méd. in Paris.\* The subject of the debate was,

\* *Bulletin de l'Académie de Méd.*, 7-16, 1282.

"Chloroform-Narcosis," and Gosselin, Labbé, Rochard, Perrin, Trélat, Verneuil, Vulpian, and other well-known authorities participated in the same. The eminent surgeons mentioned all gave their individual experience, their own peculiar mode of administering chloroform, and their opinions regarding the latter. As the whole discussion might be said to have been a resumé of the views held at present by most surgeons concerning the administration of chloroform, we bring our readers in the following, an extract of the interesting debate, and while reporting the opinions of the experienced surgeons mentioned, give the principles which should to-day govern a physician in the administration of this powerful anæsthetic.

Gosselin recognizes three methods of narcotization by chloroform;

1. Small doses are administered; five to six drops at one time, which are permitted to evaporate before more chloroform is added.

2. Large uninterrupted doses. At the very beginning two or three fluid drachms are poured upon the napkin, towel, sponge or apparatus, and the latter is then kept moist with the drug during the whole narcosis.

This method should never be employed in men, as experiments on animals have proven its great danger. Undoubtedly too much chloroform is here at once carried to the blood and in this manner to the brain and medulla oblongata.

3. Progressively increased doses with interruptions. This is the method which Gosselin practices to the exclusion of all others. About one fluid drachm is poured upon the napkin, which is kept about five inches away from the mouth of the patient, so as to allow a continuous ingress of the atmospheric air. After six to seven respirations, which are exactly counted, he permits the patient to take twice a deep breath of pure air. Chloroform is then again inhaled in the manner described for eight, nine, ten, or more times, but after each eighth, ninth, tenth, or more (always counted) act of inspiration (with the chloroform) the patient is invariably allowed to breathe twice pure air. The quantity of the chloroform poured upon the towel is gradually increased in this way

up to one and a half, two, and two and a half fluid drachms. Generally by this method within from six to twelve minutes perfect narcosis results, the patient having made about one hundred and fifty inhalations, with twenty-eight free respirations. The narcosis under these circumstances takes, according to Gosselin's own words, the following course:

1. Half sleep with preservation of consciousness.
2. Period of agitation and mild delirium.
3. Loss of consciousness, muscular contractions.
4. Deep sleep, muscular relaxation, contraction of pupils, cessation of reflex excitability.

The advantages this method offers and insures, consist in the fact that blood and nervous centres never receive too much chloroform at any one time, as in consequence of the interruptions of the narcosis a part of the chloroform is always exhaled again. Besides, it is the intention to get the nervous centres used, as it were, by the slow and interrupted supply of the drug, to the chloroform. Gosselin believes that by his method the fatal accidents due to chloroform-narcosis (according to his report in France, one death to every five thousand two hundred narcoses) are not only avoided with certainty, but that also all other dangerous accidents may be eliminated, as they are invariably based upon momentary "hyper-saturation" of the nervous centres by chloroform. He not only accepts in its full meaning the sentence of Sédillot: "*Le chloroforme pur et bien employé ne tue jamais*,"\* but he generalizes the same still more: "*Le chloroforme même légèrement impur ne donne pas la mort s'il est bien administré*."† He prides himself upon the fact that his method not alone has never caused a fatal, but neither any other dangerous accident.

Labbé is opposed to the method of Gosselin, as in consequence of the frequent interruptions narcosis is retarded, and therefore *in toto* more chloroform is used by this than by any other method. He, himself, prefers very small doses, but administered uninterruptedly, and at the same time he

\* Chloroform, if pure and well administered, never kills.

† Chloroform, even if in the usual manner impure, will never cause death, if well administered.

prevents its rapid evaporation by covering the napkin with some impermeable material.

Verneuil reports a fatal case by chloroform-narcosis, which happened to him in his own practice, after he had been in the habit, for almost thirty years, of administering the anæsthetic in the usual manner without any accident. The impurity of the chloroform is, according to him, by no means so unimportant as Gosselin thinks. Not every chloroform-death can be avoided with anything like certainty, and simply for the reason that some affections, as, for instance, fatty heart, one of the most frequent causes of death by chloroform, could not always be diagnosed with certainty. Besides sudden death, especially in the beginning of an operation, had often taken place long before chloroform was known, and he cannot see how such cases may be prevented by any change in the administration of the anæsthetic. But Verneuil finds especially fault with Gosselin, because he conducts the narcosis with all the many different patients in one and the same manner, not suiting the administration of the chloroform to the ever-varying case, but suiting any case to his peculiar method of employing the drug.

Rochard, who has had great experience with chloroform, considers it still the best narcotic, and cautions his professional brethren not to bring it into discredit. But he insists on the administration of the anæsthetic by a special apparatus, which permits the addition of the atmospheric air in a certain proportion.

How their individual experience influences the views of persons can be seen from Perrin, who with an experience similar to that of Rochard, totally discards any apparatus, and thinks the simple towel or napkin-compress to be the best and most secure. He also prefers the administration of chloroform in small but continuous doses, and insists upon the instantaneous withdrawal of the drug as soon as any accident takes place.

The greatest opponent, however, of Gosselin's view, is Trélat, who, while strictly following the method recommended so highly by the latter, lost on the very day on which Gosselin first publicly

demonstrated his peculiar manner of administering chloroform, a patient by chloroform-narcosis. Trélat draws our attention to those cases in whom death takes place some time after the withdrawal of the drug, and is of the opinion that in such cases we are perfectly powerless. At the same time he too is convinced of the great advantages chloroform has before all other anæsthetics, and he cites numerous cases belonging especially to modern surgery, where chloroform alone saved the life of persons.

Vulpian's experiments on animals seem to give a physiological explanation for the accidents by chloroform-narcosis. The dangerous symptoms at the beginning of the latter are of reflex nature, caused by the action of the drug upon the nervous centres of the respiratory organs. During the further progress of the narcosis in animals, it is possible to produce by strong mechanical irritation of the central and of the peripheral end of the vagus, stoppage of respiration and of heart's action. This cessation, which may artificially also be induced in other animals, can be caused much easier and more perfectly in animals under chloroform-narcosis. This fact proves that under the influence of chloroform the centres for respiration and circulation become altered and later paralyzed. These phenomena are not alike in all animals; in young animals of certain species of mammalia they are especially apparent. Vulpian observed in narcotized dogs that by weak faradization of the central end of the sciatic nerve, respiration is made slower, and by strong currents it totally ceases. The heart continues to beat for about one minute longer. This shows that the power of conduction of the spinal cord is not interfered with by the narcosis, surely not extinguished. By artificial respiration, if continued for about thirty minutes, one is often able to bring the animal back to life.

From a general resumé of the discussion, the following may be said to be the opinion of the French Academy of Medicine regarding chloroform-narcosis:

1. The dose of the anæsthetic should be definite, no matter how varying in different cases.



2. The chloroform should not be carried to the respiratory organs too directly or too concentrated.

3. The drug should be mixed in a constant proportion with the atmospheric air.

4. The resistance of the patient should not be overcome by force, because an exact measurement of the dose becomes impossible in this manner.

5. The inspirations should be intermitting in character; *i. e.*, inhalation of chloroform alternating with that of air.

6. Narcosis should not be carried until reflex excitability is totally extinguished, as analgesia sets in much sooner.

#### VIRUS IN OPEN WOUNDS.

M. G. Colin recently read a very interesting memoir on this subject before the Académie des Sciences.

The virulent matters, introduced into open wounds, become separated in three very unequal parts. One part becomes attached to the tissues of the wound, itself to certain of their anatomical elements and to the liquids which impregnate them; here the virus becomes momentarily or definitively fixed. It is thus that are formed the vaccinal pustule, the malignant pustule and the ulceration in farcy. The second fraction of virus spreads by simple diffusion, independent of the ordinary modes of absorption, in the surrounding cellular tissue, over a more or less extended zone, according to the anatomical conditions of the affected parts. It is this species of diffusion which gives rise to the œdema in malignant charbon, to certain forms of septic œdema supervening after grave operations, to phlegmon and erysipelas. The third part of the virulent material, which is absorbed, separates into two parts at the moment it is taken up. The fraction entering the blood-vessels is necessarily carried very rapidly into all parts of the organism. On the contrary, the part taken up by the lymphatics, is displaced very slowly, stagnates in the network of ducts where it acts as an irritant, and finally becomes arrested and accumulates in the glands, whence, through its conservation and regeneration, it has a large

part in the development of accidents consecutive to inoculation. These views demonstrate the necessity of the early and free cauterization or excision of virulent wounds to prevent the passage of the virus into the system by simple diffusion or by absorption through the blood-vessels or lymphatics.

#### POISONED ARROWS.

At a recent séance of the Soc. d'Anthropologie, an interesting communication was received from M. W. J. Hoffman regarding the methods employed by the North American Indians to poison their arrow points.

The Comanches simply pierce the green shell of the "Spanish bayonet," or *yucca angustifolia*, with the points.

It is reported that the Lipans dip the points in the menstrual blood of women.

The Apaches (Cayoteres *sic.*) bruise up the heads of rattlesnakes with fragments of deer's liver, allow the mass to become putrid, then dip the arrow points and allow them to dry slowly.

The Chinouns (Moquis of Arizona) irritate a rattlesnake until he bites himself, and then dip the point and a portion of the wood of the arrow into the blood of the animal. A wound with one of these arrows generally proves fatal in three or four days, and its action is much more rapid if the stomach of the wounded person is empty at the time the injury is received.

Another poison is obtained by irritating bees, shaking the hive, and then killing them when in this state with small branches bunched together. The insects are crushed up in a mass with mortar and pestle, and the arrow points are dipped in the magma. It is probable that the active substance in this case consists in the formic acid contained in the bodies of the bees.

This preparation does not cause death, but induces long-continued sickness.

Another very active but not fatal poison is prepared from red ants. It produces pain in the pharynx, considerable swelling of the part injured, and sometimes delirium. The patient remains feeble for a month.

**CHOLERA.**

The issue of *Puck* for July 18th contains a most striking illustration.

A vessel approaches New York, upon the bowsprit of which sits a gaunt skeleton, labeled *Cholera*.

In front of Castle Garden, to which the vessel is steering, is ranged a battery of bottles, labeled "Carbolic Acid," "Thymol," "Chloride of Lime," etc. The Board of Health in a boat are meeting the ship, while a cordon of sanitary police, brandishing clubs in the air and standing knee-deep in water, are uselessly endeavoring to drive off this unwelcome emigrant. This picture bears the suggestive and terrible title, "THE KIND OF 'ASSISTED EMIGRANT' WE CANNOT AFFORD TO ADMIT."

Nearly a year ago, we took occasion to give several warnings as to the danger of an invasion from this dread disease; but, of course, our warnings were unheeded. Cholera is now ravaging the East, it is reported in London and in Mexico, and we have every reason to fear that it may be introduced into our own country at any moment.

What can we do? Prepare to give it the cold shoulder. How? By cleanliness. Should it escape our quarantine outposts and come among us, it will not take deep root, if it does not find filth upon which to subsist. The precaution is plainly indicated; let us see to it that we do not have a terrible epidemic.

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## NOTES AND COMMENTS.

**Fatty Heart.**

M. E. Leyden, in a recent memoir (*Zeitsch. für Klin. Med. t. v.*), distinguishes two forms of this disease: the first is the lighter and more frequent form, in which the malaise is due to a simple accumulation of fat, the muscle remaining in a normal condition, and fulfilling its functions as usual.

The second form is of grave augury, characterized by dyspnoea, cardiac asthma, angina pectoris, heart weakness and dropsy. These phenomena depend:

1. On a simple weakness of the cardiac muscle, with dilatation of the left ventricle.
2. On arterio-sclerosis of the aorta and coronary arteries.

The prognosis in the second form is grave, and the diagnosis difficult.

To distinguish cases of arterio-sclerosis from those of simple polysarcy with feebleness of the heart, is not always possible; due attention must be accorded to the age of the patient and the condition of the arteries.

**Progressive Paresis from Alcohol.**

The *Journal of Nervous and Mental Diseases* for April, 1883, says that Dr. E. Régis (*L'Encephale*, January, 1883,) calls attention to the fact that it must be admitted that there are several forms of progressive paresis, differing according to the cause which engenders them, and it then remains to determine if around the true progressive paresis be not grouped several pseudo-progressive pareses. The question also arises, as has been pointed out, whether there is not a paralytic insanity as well as a paretic dementia, and whether the first arising under the influence of many causes, notably alcohol, does not end almost always in paretic dementia, but that it may be and often is cured. Had Dr. Régis a more extended experience, he would have seen that this supposed relation to etiology did not exist; that in all forms there were remissions, and these remissions have by superficial observers been looked upon as recoveries. At the same time he does not seem to be acquainted with the fact that hypomania closely resembles, in its psychical features, progressive paresis, and fails to see that this is an element vitiating some of his conclusions.

**Bacilli in the Urine.**

The *London Med. Record*, April 15, 1883, says; Although bacilli have been found in the renal pelvis, they have not been observed hitherto in the urine of the living being. This void Dr. Rosenstein is able to fill from a case under his own observation (*Centralbl. für die Med. Wiss.*). A man, aged 37, of a healthy family, and previously of good health, had for four years suffered pain in micturition, both before and after voiding urine. Two years since he first noticed hardness of the epididymis on the left side, and soon afterwards on both sides. The testicles were unaffected, as were also the inguinal glands, and there were no signs of pulmonary disease. Micturition was frequent; the specific gravity of the urine was 1012 to 1018; the urine was acid, and contained albumen. Turbid when first passed, it exhibited numerous white flocculi about the size of a pin's head. On being left to stand, a thick, grayish-white sediment was deposited, consisting

mainly of pus and a few blood-corpuscles. The white flocculi mentioned consisted of masses rich in tubercle-bacilli, which were distinguishable by staining from bacteria of putrescence.

#### The Advantages of Immediate Operation for Lacerated Cervix.

Dr. E. P. Murdock thus concludes a paper on this subject (*Western Med. Reporter*, June, 1883):

1. It is in accordance with the well established maxims of all good surgery that the operation to repair an injury should be performed at the earliest possible moment, to secure union by first intention, to prevent deformity, and to prevent sepsis.

2. It saves the patient the incalculable annoyances of preparatory treatment with its physical burdens and mental anxiety contemplating a secondary operation.

3. It gives the patient the best possible chance to escape septicaemia, subinvolution, and all the other complications which follow cervical lacerations.

4. It saves the patient much time, great expense, and avoids a deformity which in many cases would never be repaired by plastic surgery.

#### Tincture of Belladonna to Relieve Itching.

Tincture of belladonna topically used has given excellent results to Dr. B. F. Bell (*Med. Chronicle*, July, 1883), in the severe itching accompanying skin affections.

He has used it in one case of impetiginous eruption confined to the right arm, and in one case of urticaria of the hands and wrists, with the result of relief in each case.

In all, he has used it in five *light* cases of herpes zoster with the desired result. In severe cases of this affection where we have *severe pain* and *not itching*, he thinks this remedy would be of but little, if any, benefit.

He has used it in about twenty cases of eczema, of various forms and degrees, and in each case relieved the itching. In some cases he has used large quantities of it, applying it very frequently; always being governed by the effect produced and not the quantity used.

#### Foreign Bodies in the Uterus.

Dr. J. A. Wessinger very wisely calls attention to this matter in the *Med. Age*, June 25, 1883. He relates the case of a woman who, after an abortion, became very weak from repeated hemorrhages, to relieve which her husband had tamponed the vagina. This was removed, placenta

taken away, ergotin and rest prescribed, and the woman improved. A few days before the next menstrual period she had another severe hemorrhage, which was controlled by the same treatment. Again, at the approach of the next epoch, she began to suffer from a peculiar feeling of weight in the pelvis, severe pain in lower portion of spine, and offensive vaginal discharge. A careful uterine examination detected a foreign body, which upon removal proved to be a piece of cotton cloth, probably introduced by the husband when placing the tampon. Under iron and quinine the woman made a rapid recovery.

#### Alterative Medicines in Eczema.

Dr. McCall Anderson lays down the following rules in the *Journal of Cutaneous and Venereal Diseases*, for May, 1883:

1. Let the dose, at first small, be gradually increased till the medicine disagrees, or till the disease begins to yield, and then let it gradually be diminished.

2. If the medicine disagrees, do not omit it altogether without very good reason, but try it in smaller doses or in another form, or omit it for a few days until the bad effects have passed away.

3. To give it a fair trial, it must be continued for a considerable period of time, because in some cases the eruption does not disappear till after it has been administered for several weeks.

4. Do not, as a rule, permit the patient to give up taking the medicine till some weeks have elapsed since the complete disappearance of the eruption.

#### Pulse and Temperature in Typhoid Fever.

M. Malherbe, in a recent *Thèse de Paris*, remarks that the frequency of the pulse in this disease is not always in proportion with the elevation of temperature. The temperature often becomes very high without a corresponding change in the pulse, and inversely, the pulse may become very much accelerated without any extra elevation of temperature. In any febrile affection where, with a high temperature, the pulse remains almost normal in frequency, typhoid fever should be thought of. The prognosis is not generally bad when the pulse remains at 80 or 90 beats per minute, even when the temperature amounts to 104° or 105°. But when the pulse is very frequent in conjunction with this high temperature, then the prognosis is grave. When, on the other hand, the temperature suddenly falls, while the pulse remains very frequent, the prognosis is equally grave.

**Remedy for Earache.**

In the *Druggists' Circular* for July, 1883, a correspondent says:

The remedy which I here offer has, after repeated trials, never failed to afford almost instant relief. It is perfectly simple, easy of application, costs but little, and can be procured at any drug store.

Here it is with accompanying directions:

Olive oil . . . . . 1 ounce.  
Chloroform . . . . . 1 drachm.

Mix and shake well together; then pour twenty-five or thirty drops into the ear and close it up with a piece of raw cotton to exclude the air and retain the mixture.

The remedy I can truly say is a specific in earache. It acts promptly and efficiently and in my hands has never failed to effect a cure in a short space of time.

**Sexual Excesses in Adult Life as a Cause of Impotence.**

Dr. William A. Hammond has prepared a work on "Sexual Impotence in the Male," from which the *Virginia Medical Monthly*, June, 1883, makes some practical extracts. While it is a difficult matter to say accurately what constitutes excess, as it would vary in each individual case, Dr. Hammond considers that previous to the twenty-first year sexual intercourse should not be practiced at all. From twenty-one to twenty-five years, once every ten or twelve days, and from twenty-five to forty, once a week. Physiological impotence, as distinguished from pathological (the result of excesses) should be accompanied by loss of desire, while in the latter condition the desire exists and the ability is gone.

**Poisoning by Stramonium.**

Dr. Charles F. Bevan, (*Medical Chronicle*, July, 1883,) was called to see a boy aged twelve, who had chewed and swallowed about three-quarters of an ounce of the crushed leaves. The stomach was evacuated promptly, the organ washed out with a stomach-pump, bicarbonate of soda given freely, and during the course of two hours  $3\frac{1}{4}$  grs. of sulphate of morphia were given hypodermically. He was walked to prevent sleep for about four hours, and was only allowed to rest when partial consciousness had been restored, and the bright redness of the skin had disappeared. The following day he had not the slightest recollection of what had occurred; the pupils regained their sensitiveness slowly and it was over one week before they became normal.

**Puerperal Fever.**

M. Fischel has found, from large experience in the obstetrical clinic at Prague (*Arch. für Gynäk.*, t. 20), that extreme prudence is necessary in the employment of antiseptic injections into the uterus. The attention of the accoucheur should be particularly devoted to the external genital organs, for it is often through an erosion of the vagina or vulva that septic materials find an entrance into the organism.

Fischel finds the simple washing out of the vagina in most cases sufficient. He employs tincture of iodine, permanganate of potash and a five per cent. solution of carbolic acid.

**Caries of the Arytenoid Cartilages.**

At a recent meeting of the Soc. Med. des Hopitaux (May 25), M. Gouguenheim presented pathological specimens from the autopsy of a patient who died of acute phthisis presenting symptoms of typhoid fever. He had lost his voice completely some time previous to his death.

At the autopsy, in connection with the pulmonary lesions of acute phthisis, there existed caries of the arytenoid cartilages, ulceration of both vocal cords, which were almost completely destroyed, ulcerations on the free border of the epiglottis, and tuberculous infiltration of the aryteno-epiglottic folds.

**Jaccoud's Glycerine Mixture.**

(See vol. xlviii., p. 664.)

Prof. Jaccoud of the Paris Faculty recommends the following mixture of glycerine in cases where cod-liver oil is not well tolerated:

R.—Glycerinæ,	5 x.
Sp. vini gall. or rum,	3 iij.
Ol. menth. piperit,	gtt. j.
M.	

This quantity may be divided into two or three doses, and taken just after or between meals.

This mixture has an agreeable taste, is facile of digestion, and does not cause disgust, even after being used several months without intermission. Prof. Jaccoud has obtained marked benefit from its use in several cases of phthisis.

**Cold Compresses for Angina Pectoris.**

The *Weekly Medical Review*, May 26, 1883, notes that Gunsberg has treated agina pectoris (*Revue Médicale*), when due to a neurosis of the cardiac nerves, by cold compresses placed over the chest. They produce at once a diminution in intensity of pain and force of the heart-beats. They succeed best in young subjects. In older persons heat



may be substituted for cold. In conjunction he would give opium and belladonna every four hours. He has never employed hypodermics of morphine over the precordial region, but thinks they might be of advantage. He recommends gymnastic exercise as of especial benefit.

#### Petroleum for Consumptives.

The *Druggists' Circular*, July, 1883, says that Gmeiner has employed petroleum with excellent results in consumption. In one case where iodine, quinine, chloride of ammonium, and antimony did not give the patient the slightest relief, crude petroleum in its natural state caused perceptible improvement. Half a teaspoonful was given three times a day in sherry wine. In four days the pulse, that had been 120 per minute, became normal, and in less than a month the cure was complete. It is best given in capsules, as the odor is more repulsive to the patient than the taste.—*Reposit. di Chim. e Farm.* [The source of the oil is not stated, and may be important.]

#### Hydrops Chorii.

Dr. John Morris reports a case in the July number of the *Medical Chronicle* which puzzled him very much, as he feared he had to do with some serious anomaly. After rupturing the membranes and an abundant discharge of waters, a shining blue cyst appeared at the vulva. After some difficulty, he succeeded in finding the head of the child presenting normally above the brim of the pelvis. Just as the head emerged from under the pubis, this cyst suddenly burst, pouring its contents over the bed.

#### Acute Scoliosis.

M. Duprés reports a case following typhoid fever (*Union Med.*), and he sums up the treatment as follows;

1. Faradization daily, or at least every other day.
2. Rational gymnastics.
3. Physiological prosthesis of the trunk by a special corset.

Of these three methods, the first two only can prove curative.

#### Best Form of Administering Iodide and Bromide of Potassium, also Salicylate of Sodium.

From *New Remedies*, July 18, 1883, we learn the following:

According to Dr. Seguin, these salts are best exhibited in slightly alkaline, natural or artificial carbonated waters. Given in this manner, both the iodide and the bromide are less irritating to the

mucous membrane of the stomach, the disagreeable taste is very much masked, and the salts are more quickly and more thoroughly absorbed.

Salicylate of sodium is best administered in the same manner.

#### The Treatment of Epilepsy.

In the course of an interesting lecture on epilepsy, translated from the French of Prof. B. Ball, by Dr. E. P. Hurd, and published in the *North Carolina Medical Journal*, May, 1883, the author deprecates the prolonged use of the bromides, which, while giving excellent results from the point of view of the convulsive attacks, may, in the long run, bring about a sensible impairment of the mental faculties. He prefers the mixed treatment, associating oxide of zinc and belladonna with the alkaline bromides.

#### The Uses of Creasote.

From the *Analyst*, No. 80, vol. 7, we learn that pure creasote, not carbolic acid, proves beneficial to consumptives and sufferers from chronic catarrh; it is also markedly anti-asthmatic. The proper adult dose is from  $\frac{1}{4}$  to  $\frac{3}{4}$  of a grain two or three times daily. The maximum single dose is  $\frac{3}{4}$  of a grain. It is best given in pills made by melting two parts of yellow wax and one of creasote, to which any other ingredients desired may be added.

#### Syrup of Castor Oil.

The following formula is taken from the *Farmacista Italiana*: Picked gum arabic, grams 54; orange-flower water, grams 142. Make a thick mucilage with a portion of water, and in a marble mortar; mix this with 142 grams of fresh castor oil until perfectly mixed; add finely-powdered sugar, grams 196; the rest of the orange-flower water and 8 grams of cinnamon-water. After well mixing in the cold, raise it by a gentle heat to the boiling point; cool, skim, and preserve.

#### Induration of the Corpus Cavernosum of the Penis.

Several cases of hardness occurring along the corpus cavernosum and limiting erection are reported by M. Verneuil in *Bull. et Mem. de la Soc. de Chirurg. de Paris*, December, 1882. It is due to syphilis and gout; and all treatment has proved unavailing in his hands.

#### Intestinal Concretions.

Dr. Schuberg (*Virchow's Archives*, vol. xc. p. 73) says that their chief seat is the cæcum. The occurrence of eighty per cent. of all cases in men,

and only twenty in women, he attributes to the habit of biting the beard, the hair acting as a nucleus.

#### Buck's Extension for Sciatica.

Dr. John R. Buchan reports in the *Weekly Medical Review*, June 23, 1883, five cases of obstinate sciatica, eventually relieved by extension, and only one case in which it failed. About eight pounds was the weight used. This method of treatment is rational, and in all cases deserves a fair trial.

#### Powder for Migraine.

R. Quinidiæ sulphat.,	gr. xxiv.
Caffeinæ.	
Acidi tartarici,	ãã gr. xvj.
Morphiæ,	gr. 3.
Sacch. alb.,	3 ijs.

Mix, and divide into five equal parts—one to be taken morning and evening, alone or in a cup of coffee without milk.

#### Resorcin for Chancres.

This article has been recently used with considerable success as a substitute for iodoform in the dressing of chancres by Dr. Leblond. It is used in powder and also in solution, made by dissolving resorcin in distilled water in the proportion of twenty-five per cent.

#### Antidotes for Strychnia.

Dr. McReddie (*Brit. Med. Jour.*, May 19, 1883,) has experimented with chloroform, amyl nitrite, atropine, and eserine. He finds that all these remedies are inefficacious, neither preventing the fatal result, nor arresting the convulsions.

#### The Nature of Soft Chancre.

From the *Med. Chrr. Centralb.*, February 16, 1883, we learn that Dr. Moritz Winter believes that the so-called soft chancre originates from a modification of the syphilitic virus, but is then a separate disease, and can never serve as a source of pure syphilitic contagion.

#### Case of Central Scotoma with Derangement of Color Perception.

Dr. David Webster reports a case in the *Med. Record*, June 9, 1883, wherein a complete cure followed the daily hypodermic use of nitrate of strychnia commenced in small doses, and cautiously increased until the physiological effects of the drug were produced.

## CORRESPONDENCE.

### Report of a Case of Hydatiform Mole.

EDS. MED. AND SURG. REPORTER:—

On June 26 I was called to see Mrs. K—, æt. twenty-five years, who gave me the following history: Perfectly well and menstruating regularly since the birth of her last child up to June 17, with the exception of occasional vomiting after eating. On this day she had taken a buggy ride of a couple of miles, and she had returned home with pain in the abdomen and pelvic region. She also noticed her abdomen to be enlarging. On June 23 she had a large flow of blood from the genitals, which she supposed to be her menses, and on the following morning clots passed away. During all this time the abdomen kept steadily enlarging.

Dr. — (a homœopath) was called to see her, but gave the family no satisfaction whatever. I found the uterus as large as at the sixth month of gestation, the lower segment considerably developed, and the neck rather soft. The finger could be inserted as far as the internal orifice. I left her morphia for the relief of pain, and dilute sulphuric acid gtt. x. to xv. every four hours, and deferred positive diagnosis until the following day, when Dr. I. N. Grubb, my preceptor and partner, examined the case, and the diagnosis of uterine hydatid was made. Fld. ext. ergot was administered, as the pains seemed inevitable, and the patient expelled, together with a large quantity of fluid and clotted blood, a multitude of hydatiform vesicles, mostly in clusters. The whole collection would have measured three quarts. Her pulse now continued at 130. Thorough cleanliness of patient, bed and surroundings was ordered, together with the internal administration of sulphate of quinine in solution, and light stimulating diet of milk, wine, etc. The uterus was ordered to be syringed out three times a day with carbolyzed water. About midnight, June 28, our patient was seized with a chill, and in the morning she had considerable fever, vagina hot and tender along the left antero-lateral aspect; pulse 140. The treatment was continued as before, except increasing the doses of quinine. Her condition remained the same up to July 2, when the pulse fell to 138. She feels nauseated, dizzy, and sees black specks before her eyes (an indication of cerebral anæmia) when she attempts to rise up in bed. Tr. ferri. chlor. was now added to the quinine. On July 3, her pulse was down to 130, and her general condition improved. She is talkative, inquires of her sick neighbors, and orders the conduct of her children. On the following day her pulse fell to 96 per minute, possibly due to the purgative action of castor oil. She complains of some abdominal tenderness, which passes off in a day or two. Her pulse now continued from 90 to 116, until complete convalescence. On July 9, she complained of some atonicity of the bladder, which was promptly relieved by the administration of tr. belladonna. She commenced sitting up on July 11, and at the time of writing, July 16, the woman is virtually well.

I have thought it well to report this case, as they are among the rare cases we meet with, and

we usually read of them as being difficult to diagnose. However, with a history like this woman gave, if the statements can be relied on, the diagnosis should be easy. These patients also require very careful handling, with thorough attention to hygienic surroundings, and dependence upon the sulphate of quinine as the only internal antiseptic remedy.

A. D. VAN DYKE, M. D.

Thompsonstown, Pa., July 19, 1883.

#### A Card From Dr. Agnew.

EDS. MED. AND SURG. REPORTER:—

I am receiving letters from various sections of the country asking for information in regard to my connection with a little volume published by a Dr. Samuel Miller, and entitled *An Epitome of Medicine, Surgery, and Obstetrics*, by Drs. Stillé, Agnew and Penrose.

I have no desire to increase my correspondence, already too onerous, and therefore deem it best to avail myself of the columns of your widely circulated journal to inform my professional brethren that I have no relation whatever with this miserable piece of literary larceny, published entirely without my knowledge, and only remarkable for inaccuracy, stupidity, and audacity on the part of its author.

D. HAYES AGNEW, M. D.

July 21, 1883.

## NEWS AND MISCELLANY.

### Some Typhoid Epidemics of the Past Decade, and the Necessity of Compulsory Disinfection.

Under this title Dr. Morton Prince contributed an article to the *Boston M. and S. Journal*, March 1, 1883, from which we extract the following salient points:

"We learn from the last report of the Board of Health that the sewage of the town of Natick, a town of over eight thousand inhabitants, is daily passing into Cochituate lake, being only opposed by a dam, through which it filters. There can be little doubt that the only thing which saves us from some extensive epidemic in this city is the vast dilution which this filth undergoes before being consumed. How long this safeguard will last, no one can say. Whatever amount of sewage fails to reach the consumer of water is settling to the bottom of the lake, there to form a sediment of greater or less extent."

"The danger of allowing the discharge to be thrown without disinfection into the sewers may be understood from the following facts: During the past year the Board of Health, following its usual custom, examined a large number of houses in eleven different sections of the city, and occupied by all classes of the community. The examinations are made without any previous knowledge of the sanitary conditions of the houses:

"The total number examined was 491.

"The number in which bad odors were found was 332.

"The number in which defective drains were found was 279.

"The number in which defective trapping was found was 210.

"The number having offensive privy vaults was 72.

"The number having offensive water-closets was 50:

"While those having ventilation to the soil pipe or drain was only 40."

"It has been calculated that there are 10,000 persons sick with typhoid every year in this State (Massachusetts) alone. In England Dr. Budd, as far back as 1859, calculated the number to be from 100,000 to 150,000, and Dr. MacLagan, in 1879, at 200,000. In other words, however unpoetical it may sound, we have in this State an army of 10,000 intestines discharging daily for a number of weeks each year a most virulent poison into the outer world. Is it any wonder, then, that we cannot follow each germ in its wanderings over the land, or trace back every case of fever to the germ which took root in its soil?"

### The St. Louis Medical Society and the Code of Ethics.

HALL OF THE ST. LOUIS MEDICAL SOCIETY,  
POLYTECHNIC BUILDING, COR. 7TH AND  
CHESTNUT STS., June 23, 1883.

On June 23, 1883, Dr. Atwood introduced the following, which was adopted by the St. Louis Medical Society, after some considerable discussion:

WHEREAS, At the recent session of the American Medical Association, a preamble and resolution were offered for the consideration of said Association, purporting to represent the sense of the St. Louis Medical Society upon the propriety of preparing a new code of ethics, or altering and changing the existing code in accordance with the present relations of the profession; and,

WHEREAS, In said preamble the assertion is made that, "the code has accomplished all it was designed it should, but at present many of its features are obsolete and not adapted to our wants. The necessity of an early revision is very apparent, is loudly called for in all parts of our land, and cannot be repressed much longer. \* \* \*

The time has come when the loud and very soon universal call will have to be heeded"; and,

WHEREAS, The St. Louis Medical Society did not instruct, "That the committee be authorized to prepare a code of ethics which in their view will meet the wishes of the profession, and submit the same to the meeting of 1884"; therefore,

Resolved, That the St. Louis Medical Society distinctly repudiates the statements contained in said preamble, and again expresses its fealty to the existing code of ethics as a time-honored and most suitable fundamental law of the profession, and specially deprecates any action calculated to reflect upon its loyalty to those principles which have heretofore secured immunity from the machinations of schismatics within or enemies without.

A. H. OHMANN-DUMESNIL, M. D.,

Recording Secretary.

### Aged Philadelphians.

During the first six months of 1883 the deaths announced in the obituary columns of the *Public Ledger* of persons who had lived to or beyond the advanced age of 80 years numbered 509—217 men and 292 women—a greater number than had

previously been announced during any corresponding period. Four were centenarians—Mary Ann Conrad, a native of Bavaria, and relict of Henry Conrad, a soldier under Napoleon Bonaparte, died January 29th. She was 103 years, 1 month and 3 days old, and left 20 grandchildren and 12 great-grandchildren. Mrs. Martha Forrest died February 14, aged 104 years. She was born in Ireland, and when she arrived at Castle Garden in 1863, she even then presented so aged an appearance that the Commissioners of Emigration would not permit her to land until security was given that she would not on account of her age become a charge on the county. Josiah Galbraith, a native of Ireland, died February 17, at the reputed age of 107 years, and was said to have followed the occupation of a bobbin-winder until he was 102 years old. He was in good health until within a few days of his death, which was caused by paralysis, and was survived by only one of his six children. The fourth of the centenarians was Margaret Cuff, who died March 16, at the Home for Aged and Infirm Colored Persons, aged 103 years.

#### Waterproof Lac.

The lac with which gossamer and other articles made out of gutta percha were covered to give them their shiny appearance, but without having any detrimental influence upon the water-proof properties of the same, has so far been kept a secret. The *Deutsch-Amerik. Apoth. Zeit.*, New York, No. 23, 1883, now publishes the receipt; and as the same may be made useful for many purposes coming within the province of the physician, we translate it for the benefit of those of our readers that may possibly wish to use it:

R. Gm. lac,	600 grm.
Borax,	200 "
Anilin black,	2-3 "

The borax is dissolved in hot water, the lac gradually added, the whole boiled to perfect solution and the anilin at last added. This lac is waterproof and is applied by being spread over the article with a linen rag dipped into the solution. As one can see this lac is very cheap.

More expensive is the following receipt: One part of common black gutta percha is dissolved in five to six parts of sulphuretted carbon and applied with a camel's-hair brush. This lac possesses the property of always being elastic, no matter to what temperature of our atmosphere it may be exposed.

#### What is Virtue?

The *Weekly Med. Review* is responsible for the following:

The Emperor Sigismund, in conversation with Theodor, Archbishop of Cologne, asked the Primate how he ought to act so as to obtain happiness. "We cannot, sire, expect it in this world." "What, then, is the way to gain happiness hereafter?" "You must live virtuously." "What do you mean by that expression?" "I mean," answered the Archbishop, "that you should always pursue the plan of conduct which you promise to follow when laboring under a fit of gout or indigestion."

#### To Protect Surgical Instruments.

The following is recommended by Prof. Olmstead, of Yale College, (*Pop. Sci. News*): Melt slowly together six or eight parts of lard to one of resin, and stir until it is cool. Rubbed on a bright metallic surface, it protects the polish effectually. It can be wiped off nearly clean, if it is desired, as in case of knife blades, or it can be thinned with coal oil or benzine. The surface should be both bright and dry, as it will not prevent the continuance of oxidation already begun.

#### Anecdote of Abernethy.

Abernethy being actively engaged in inserting a cervical seton in "a noble patient," who had requested that this should be done, his patient exclaimed, "Sir, you give me excessive torture; will your seton do good?" "No, sir," said the Doctor. "Then why do you insert it?" screamed the patient. "Because," said the doctor, "you told me to do so, and I will get five pounds for my work."

#### French Census Returns.

The complete returns of the last French census show that the female sex exceeds the male by 92,254—thus, males 18,656,518, females 18,748,772. Of the males 10,110,601 are unmarried and 1,025,731 widowers; while of the females, 9,280,862 are unmarried and 1,964,557 widows. The total number of inhabitants is 37,405,290.

#### Items.

—Dr. Louvain, of Carlsbad, has met with several cases in which difficulty of breathing was due to the administration of moderate doses of salicylic acid; the breathing was labored and rapid.—*Berl. Klinische Wochenschr.*, 1883, No. 16.

—A bust of Professor Erichsen and a sum of money were presented to him a few weeks ago by a number of his pupils and admirers. The bust is deposited in the University College. Mr. Erichsen will use the money to found a prize for skill in operative surgery.

—Boy to druggist—Want a boy?

Druggist—Yes. Ever worked in a drug store?

Boy—Yes, sir.

Druggist—What did you do?

Boy—Bit holes in porous plasters.

Rapid exit of boy, followed by a bottle of mucilage.

—"Charley!" "Yes, sir!" "Have you closed the store?" "Yes, sir." "Have you watered the molasses?" "Yes, sir." "Have you sanded the sugar?" "Yes, sir." "And done the other things?" "All right, sir." "Well, then, you may come in to prayers."

—At his own expense a physician tells a story about a small donkey he sent to his country house for the use of his children. One of his little daughters going out with the nurse to admire the animal in the paddock, was distressed when the donkey brayed dolefully. "Poor thing, poor thing!" she exclaimed, and turned to her nurse and said: "Oh, I am so glad! Papa will be here on Saturday, and then it won't feel so lonesome."